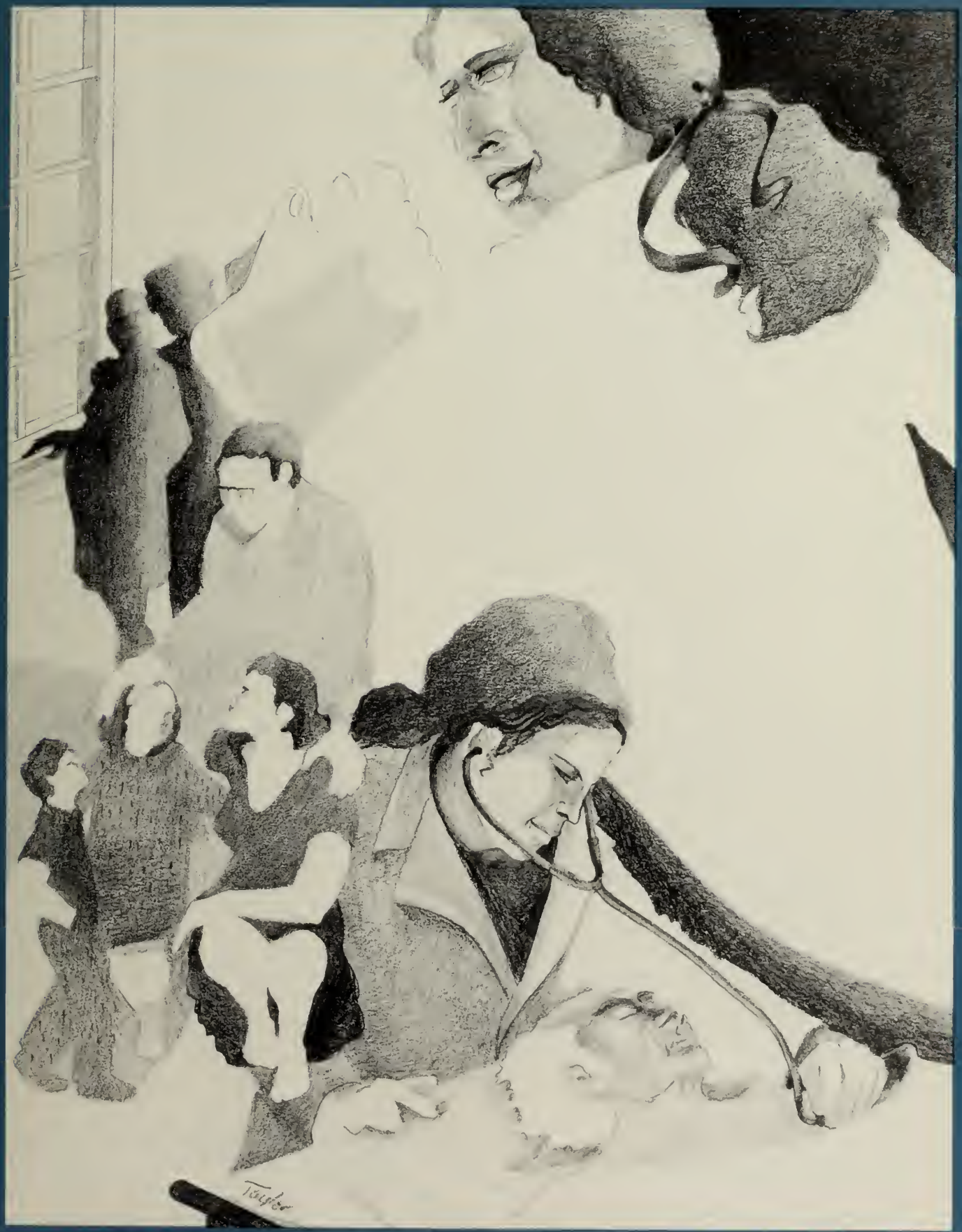

Harvard Medical Alumni Bulletin
September/ October 1975

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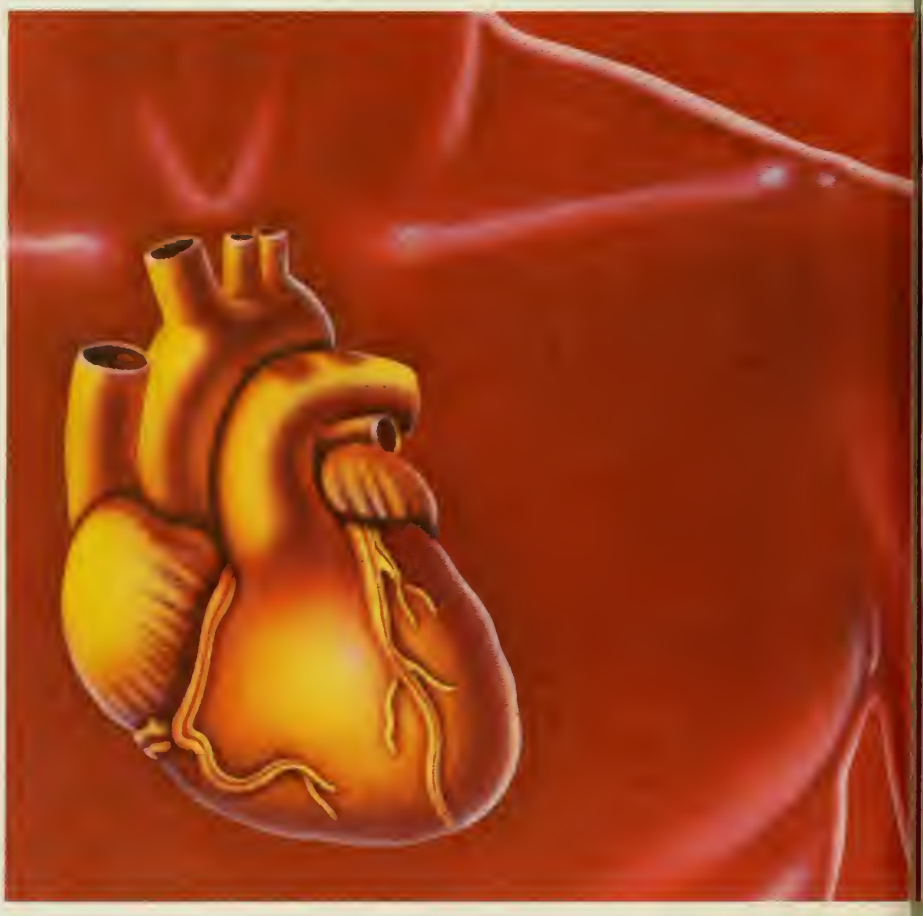
HOW MUCH PRODUCTIVE IN THE

Approximately 70% of deaths caused by acute myocardial infarction take place before the patient reaches the hospital.[1] Delay in obtaining medical care is cited as a major cause for this high incidence, and denial may contribute to this delay.

This denial in the cardiac patient is a more obvious aspect of anxiety that is *not* productive. There are others; for example, the previously self-reliant patient who, on finding himself suddenly dependent, reacts with hostility, refuses to cooperate and thus causes serious problems during the intensive care and early rehabilitative stages of his hospitalization.

Even more common, perhaps, is the postcoronary patient who fears a return to work and other everyday activities. The basis for this "cardiac neurosis" is the patient's notion that activity itself is life-threatening.[2]



When anxiety is productive

A certain amount of anxiety in the cardiac patient is both realistic and normal. And in some patients it can be productive. In the acute phase of the disease, it can prompt the patient to seek immediate medical attention. Later, it can encourage cooperation during hospitalization.

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Channeling anxiety into productive areas

Because unresolved anxiety can lead to psychologic defense mechanisms, such as denial, which may interfere with treatment of the patient, open and ample discussion between physician and patient must be maintained and encouraged. In this way, the patient can verbalize his fears and the physician can help alleviate the patient's anxiety through reassurance and counseling.

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ANXIETY IS CARDIAC PATIENT?

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References: 1. Zohman BL: *Geriatrics 28*:110-119, Feb 1973. 2. Keegan DL: *Can Fam Physician 19*(3):66-68, Mar 1973.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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Overview

Five Professors Voted Emeriti

Five members of the Faculty of Medicine have been voted emeritus status by the President and Fellows of Harvard College. Those so honored are:

J. Hartwell Harrison, M.D., Elliott Carr Cutler Professor of Surgery, emeritus;
Charles A. Janeway, M.D., Thomas Morgan Rotch Professor of Pediatrics, emeritus;
Edward B. D. Neuhauser, M.D., professor of radiology at the Children's Hospital, emeritus;
David D. Rutstein '34, Ridley Watts Professor of Preventive Medicine, emeritus; and
Louis Zetzel '34, clinical professor of medicine, emeritus.

Alumni To Rejuvenate Vanderbilt

Vanderbilt Hall, which has been subjected to fifty years of constant use, needs renovation. The task force of alumni presidents, along with the development office, hopes to raise the million dollars needed, from alumni, faculty, friends and students. The planned changes — an overhaul of the eletrical and plumbing systems, and installation of a security system; redesigned living quarters, recreational facilities, and common rooms — will be staged over a four year period, from 1975-1979. The proposed renovation will offer suites of two, three, and four bedrooms for those who want a more apartment-like lifestyle, while individual bedrooms will be modernized and available too. Smaller lounges will accommodate small groups of students who will be able to socialize without disturbing those who wish to study in their rooms. Also, students would like to see the Deanery converted into a pub conducive to a relaxed atmosphere in the evenings.

In their survey of student attitudes, the Alumni Survey Committee pinpointed the deteriorated conditions of Vanderbilt Hall as a contributing factor to student dissatisfaction. The dormitory, however, has always been filled to capacity, and these improvements will once again make Vanderbilt Hall the nucleus for students living both within and without it.

With generous alumni support, Vanderbilt Hall can bring a positive influence to student life. The Alumni Council voted to credit contributions to the donor's class record in addition to annual giving. Sponsoring Vanderbilt Hall's renovation is an ideal opportunity to express to the Medical School and its students, the scope of alumni power.

Four Faculty Women To Counsel Students

Four women members of the HMS faculty have been appointed by Dean Robert H. Ebert to work as adjuncts to the Student Affairs Office, offering counseling to students. They are: Shirley G. Driscoll, M.D., professor of pathology at the Boston Hospital for Women; Carol C. Nadelson, M.D., assistant professor of psychiatry at the Beth Israel Hospital; Malkah T. Notman, M.D., assistant clinical professor of psychiatry at HMS; and Dorothy B. Villee, M.D., assistant professor of pediatrics at HMS.

The four women are available to all students for counseling and will also participate in other Student Affairs activities; however, their appointment was made with a particular view to the special problems of women students and their expressed need for female physician counselors and role models.

Film Series Focuses on Lives of Six Medical Leaders

This year, the film and discussion program on leaders in American medicine will focus on the lives and achievements of six distinguished physicians. The series, chaired by George E. Gifford, Jr., M.D. — and sponsored by the Benjamin Waterhouse Medical History Society, the Boston Medical Library, Boston University School of Medicine, Brown University Medical School, and Tufts Medical School — will be held at the Countway Library and is open to the public. The program has been underwritten by a grant from the Josiah Macy Jr. Foundation to the Section on History of Medicine, Boston University School of Medicine.

The subjects, the dates of presentation, and the discussants are:

Helen B. Taussig, Wednesday, October 8, 1975. Discussants: Helen B. Taussig, M.D., professor of pediatrics, emerita, Johns Hopkins University; Helen S. Pittman, M.D., board of consultants, Massachusetts General Hospital; Mary Ellen Avery, M.D., pediatrician-in-chief, Children's Hospital, Thomas Morgan Rotch Professor of Pediatrics, Harvard Medical School. Dr. Taussig is known for the diagnosis and treatment of congenital heart disease.

Owen H. Wangensteen, Wednesday, November 12, 1975. Discussants: Owen H. Wangensteen, M.D., Regents' Professor of Surgery, University of Minnesota; John J. Byrne, M.D., professor of surgery and sociomedical sciences, Boston University. Dr. Wangensteen is considered to be the dean of American surgery.

Charles B. Huggins, Wednesday, February 11, 1976. Discussants: Charles B. Huggins, M.D., Nobel Laureate (1966); William D. Odgen, Distinguished Service Professor of Surgery, University of Chicago; Emil Frei, 3d, M.D., director and physician-in-chief at Sidney Farber Cancer Center, professor of medicine, Harvard Medical School. Dr. Huggins first demonstrated that carcinoma of the prostate is amenable to hormone therapy.

Joseph T. Wearn, Wednesday, March 10, 1976. Discussants: Joseph T. Wearn, M.D., Dean of Case-Western Reserve University (1945-1960); Robert H. Ebert, M.D., Dean, Harvard Medical School. Dr. Wearn was one of the foremost medical school deans in the twentieth century. He also authored the Peabody Reports on Harvard Medical School.

George L. Engel, Thursday, April 8, 1976. Discussants: George L. Engel, M.D., professor of medicine and psychiatry, University of Rochester School of Medicine and Dentistry; Sanford I. Cohen, M.D., professor of psychiatry and chairman of the department, Boston University; Jack Ewalt, M.D., Associate Dean for Academic Affairs, Bullard Professor of Psychiatry, Harvard Medical School. Dr. Engel has been a significant figure in the history of psychosomatic medicine in America.

George W. Corner, Wednesday, May 12, 1976. Discussants: George W. Corner, M.D., director of department of embryology at Carnegie Institute (1940-1955) and executive officer at American Philosophical Society; John Z. Bowers, M.D., president of Josiah Macy Jr. Foundation. Dr. Corner was the first to isolate progesterone.

Refreshments will be served at 4:00 p.m. prior to each film and discussion, which will being at 4:30 p.m. All these films were produced by Alpha Omega Alpha and the National Library of Medicine as part of a series, *Leaders in American Medicine, the Autobiographical Memoirs of Eminent Medical Scientists and Teachers*.

PROMOTIONS

Professor

Chester A. Alper '56: pediatrics at the Children's Hospital Medical Center
Howard P. Baden '56: dermatology
Thomas W. Botsford '35: surgery at the Peter Bent Brigham Hospital
John F. Burke '51: surgery
Shirley G. Driscoll: pathology at the Boston Hospital for Women
Daniel H. Funkenstein: psychiatry at the Massachusetts Mental Health Center
John T. Potts, Jr.: medicine
Edward W. Webster: radiology (physics) at the Massachusetts General Hospital

Clinical Professor

Theodore B. Bayles '36: medicine
William H. Harris: orthopedic surgery

Associate Professor with tenure

George Th. Diamandopoulos: pathology

Associate Professor

Porter W. Anderson, Jr.: microbiology and molecular genetics
G. Octo Barnett '56: medicine at the MGH
James R. Cassady '63: radiation therapy at the Joint Center for Radiation Therapy
Lawrence H. Cohn: surgery at the PBBH
Joseph L. Dorsey '64: medicine at the Harvard Community Health Plan
Michael Field: medicine
Fredric D. Frigoletto, Jr.: obstetrics and gynecology at the BHW
Edward J. Goetzl '66: medicine
C. Thomas Griffiths: obstetrics and gynecology at the BHW
Homayoun Kazemi: medicine at the MGH

Gerald M. Kolodny: radiology
Uel J. McMahan: neurobiology
H. Richard Nesson: medicine at the Beth Israel Hospital
Richard C. Pfister: radiology at the MGH
Anthony J. Piro: radiation therapy at the JCRT
Robert R. Rando: pharmacology
Dwight R. Robinson: medicine at the MGH
Graeme B. Ryan: pathology
Victor E. Shashoua: biological chemistry
Edward H. Smith: radiology at the PBBH
Thomas P. Stossel '67: pediatrics
Denise J. Strieder: pediatrics at the CHMC
Bryan P. Toole: medicine (biology)
W. Allan Walker: pediatrics
William B. Weglicki: medicine
Robert H. Wilkinson: radiology at the CHMC
Shirley H. Wray: neurology at the MGH

Associate Clinical Professor

R. Clement Darling: surgery
Robert M. Goldwyn '56: surgery
A. Louis McGarry: psychiatry
Donald H. Russell: psychiatry
Bernardo A. G. Santamarina: obstetrics and gynecology
Richard J. Smith: orthopedic surgery
Stanley M. Wyman '39: radiology

Senior Research Associate

Marjorie B. Lees: biological chemistry

Assistant Professor

William H. Anderson: psychiatry at the MGH
Damon R. Averill, Jr.: pathology (veterinary pathology) at the CHMC
Thomas F. Babor: psychology in the department of psychiatry
Ann S. Baker: medicine at the MGH
George A. Beller: medicine at the MGH
Merle J. Berger: obstetrics and gynecology at the PBBH
Robert S. Brown: medicine at the BIH
Jorge F. Calle: physiology in the department of medicine
W. Hallowell Churchill, Jr.: medicine at the PBBH
Gilbert H. Daniels: medicine at the MGH
Valentina Clark Donahue '67: obstetrics and gynecology at the BIH
James M. Donovan: psychology in the department of psychiatry at the PBBH
Michael G. Ehrlich: orthopedic surgery
Joseph M. Garfield: anesthesia at the PBBH
M. Robert Garovoy: medicine at the PBBH
Robert L. Goodman: radiation therapy at the JCRT
Terri Grodzicker: microbiology and molecular genetics
Arthur S. Grove, Jr.: ophthalmology at the Massachusetts Eye and Ear Infirmary
Charles A. Hales: medicine at the MGH
Leonard B. Kaban '73: oral surgery at the PBBH
Lester Kalisher: radiology at the MGH
David J. Kanarek: medicine at the MGH
John C. Kuehnle: psychiatry at the McLean Hospital
Raul LaGuarda: medicine at the BIH
Lewis Landsberg: medicine at the BIH
Deborah Pavan Langston: ophthalmology at the MEEI
Robert L. Lebowitz: radiology at the CHMC
Richard W. Linck: anatomy
Thomas F. Linsenmayer: anatomy
Matthew S. Loewenstein '67: medicine at the Boston City Hospital
Robert W. McCarley '64: psychiatry at the MMHC
Steven M. Mirin: psychiatry at the MH
Martin C. Moore Ede: physiology
Robert A. Peterson: ophthalmology at the CHMC
Eli C. Ridgway 3d: medicine at the MGH
Mark Roffman: psychobiology in the department of psychiatry
John M. Shane: obstetrics and gynecology at the BIH
Phillip G. Stubblefield '66: obstetrics and gynecology at the BHW
Norman J. Uretsky: neuropathology
Stephen G. Waxman: neurology
Howard A. Wishnie: psychiatry at the Cambridge Hospital

Assistant Clinical Professor

Nicholas C. Avery: psychiatry
Tully Benaron: psychiatry
Samuel J. Braun: psychiatry at the CH
Eugene P. Clerkin: medicine
William Franklin: medicine
Anne F. Godley: medicine
Robert H. McCarter: psychiatry
Frederick Pei Li: medicine
Christopher V. Rowland, Jr.: psychiatry
Liza Yessayan: neurology

Principal Associate

Richard J. Bonier: psychiatry (psychology)
Paul E. Touchette: neurology (psychology)

Principal Research Associate

James L. Burchfiel: neurobiology (neurophysiology)
Annette A. Herscovics: biological chemistry

APPOINTMENTS

Associate Professor

Sterling D. Garrard: pediatrics at the Walter E. Fernald State School

Assistant Professor

Harrison D. Cavanagh: ophthalmology
John F. Morrow: biological chemistry
Robert G. G. Russell: medicine
Michael Syvanen: microbiology and molecular genetics

Principal Research Associate

Firoze B. Jungalwala: neurology (biochemistry)

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Editorials

My Daughter, the Doctor

We are entering the age foretold by Norbert Weiner, Doctor Cyberneticus, when automation will have taken over all the mindless jobs and more and more brains will be needed at the top to man the technocracy. Meanwhile, the learned professions, and medicine in particular, will need as much brains as ever — or more.

I should have said, of course, to *person* the technocracy, because we will no longer be able to waste half of the available brainpower, the female half. One expects science, including medical science, to be the leader in this trend, and it is interesting to see how much (or how little) is happening at the present time. Our readers are referred to the editorial by Betty M. Vetter in *Science*. The data show a very small participation of women in science, with the presence of women falling at each higher level of degree, salary, academic rank, and administrative responsibility. To quote:

*In medicine, where the proportion of women is increasing faster than in most other fields of science, women comprised 11.1 percent of the 1974 graduating class but 18 percent of the total enrollment and 22.2 percent of the first-year enrollment. However, only 7 percent of practicing physicians are women, and they are concentrated in the less prestigious, less well paid specialties.**

Is it possible that medicine does not require the best brains, so that a draft of women is less urgent in our field? The late Learned Hand, Judge of the Circuit Court of Appeals in New York and noted for his judicial wisdom, used to complain privately of the ineptitude of some of the lawyers who appeared before him. Then he would reflect that the man was probably the brightest member of his family, and that his brother was probably a doctor, and that he, the judge, might be doomed to go to him. Most Harvard alumni would not accept this second-class status for medicine, however, and quite rightly many are, or will be, looking to their daughters as well as their sons to carry the torch of medical progress. Harvard Medical School is ready to help them, with affirmative policies which to this writer seem to be a fair adjustment of a market which has too long been rigged the other way. There are as many different kinds of women as there are men — let a thousand lifestyles bloom!

It may be noted that women in science are not necessarily helped by the established Women of Science. At a recent meeting of the organizing committee of a prestigious scientific society in the field of biology the subject of affirmative action for women came up. Two members, Women of Science, held negative views — "They can get it where I got it," snorted one. Does the battered child become the battering parent? We hope that women at HMS will be spared both the need to overuse aggressiveness and the paranoia that threaten the victim of many micro-inequities.

In this issue we turn our attention to women at HMS today, to women who are graduates of HMS, and to the wives of HMS graduates. And, by the way, we would like to take this occasion to salute the first HMS undergraduate to follow in his mother's footsteps — Walter R. Weiss '78, son of Ruth Stern Weiss '51. We hope that the readership of the *Bulletin* will at least double in the families of some of our alumni and that, for once, it will hold greater interest for our alumnae.

G.S.R.

Sex is the Issue

Women working for change at Harvard Medical School, and elsewhere, need a mandate that will allow them to make constructive criticisms and to proceed in their chosen field without their sex being at issue. A long view reveals that attitudes at Harvard towards women have often been rather benighted. In 1920 Nobel Laureate Marie Curie was refused an honorary doctorate in part because a Harvard professor claimed that her pioneering research was done with her husband, not alone, and that she had done nothing of comparable significance since his death. It has taken over thirty years for the statistics regarding admission of women to HMS to show any appreciable increase — from approximately eight and a half per cent in 1949 to thirty-five per cent in 1979. Many more years will elapse before HMS alumnae represent a more equal share of the total number of living graduates. As for rectifying imbalances on the faculty end of the spectrum — that too has fluctuated, but not, as might be expected, according to the dictates of affirmative action. In 1959-60, there were proportionately more women Members of the Faculty at the School of Public Health (sixteen per cent) than in 1974-75 (twelve per cent)! But at the Medical School, the percentage of women faculty has steadily increased over the past three years. Currently, of the Members of the Faculty of Medicine women account for approximately seven per cent.

The Joint Committee on the Status of Women has substantiated Harvard's shortcomings in light of affirmative action laws, and has initiated projects encouraging Harvard to adopt an equitable posture towards women — in word and in deed. Yet the Committee is in danger of losing its funding after June 1976.

Despite the precarious nature of women's liberation at HMS, a nascent optimism filters out of the articles in this issue, emanating from a variety of spheres of activity among women at Harvard and women in medicine. The sensitivities highlighted are those experienced most indubitably by women, but we hope the ramifications of these diverse personal sentiments and factual statements will reach men as well.

D.W.M.

* Vetter, "Women and Minority Scientists," *Science* 189 (4205): 751, Sept. 5, 1975. The report from which it quotes is "Professional Women and Minorities — a Manpower Data Resource Service," Scientific Manpower Commission, 1776 Massachusetts Avenue NW, Washington, D.C. 20036.

The Hazards of Feminine Physicianhood

by Nancy B. Kaltreider '64

"There are three classes of human beings: men, women, and women physicians."
Sir William Osler

The practice of medicine is no longer closed to all but the most foolhardy of women. However, in both numbers and pattern of practice, the woman physician in the United States is unusual. For her, the decision to enter medicine generally means eventually taking on the commitment of a career, marriage and motherhood. The choice of multiple role functions provides the woman physician with an overwhelming responsibility — how can she feel free to neglect any of her jobs when she herself has chosen them? Medical schools are quick to remind her that she took the place of an equally competent and presumably more career-oriented male counterpart.

There are special hazards for women throughout the isolation of their medical careers. The woman submerged by obligation is particularly prone to role-diffusion and guilt over her inabiltiy to meet superhuman standards. This article will consider some thoughts drawn from my own and others' experience in an attempt to examine the pattern of attitudinal bias and to demonstrate the need for a strong core identity in the woman physician.

The low national percentage of women in medicine has remained relatively constant over the last fifty years, in contrast to most other countries in which the woman physician is increasingly prominent. Despite rumors of quota systems, the number of women accepted into medical schools in this country is proportionate to the number of applicants and is slightly more favorable than the male acceptance rate. With the recent positive recruitment

Dr. Kaltreider is an assistant clinical professor at the Langley Porter Neuropsychiatric Institute of the University of California Medical Center at San Francisco. She is also working with the gynecology clinic there on several research projects involving women: women who never want to have children and the meaning of bisexuality in women. She is in private practice and is married to H. Benfer Kaltreider '65.

programs, the percentage of accepted women in the Fall, 1971 class was 13.7%, an increase of 34.8% over 1970.[1] Now that the entrance-way has been smoothed for women, discrimination is apparent at the higher levels. This lag may be partially explained by the widespread attitude that a woman's divided loyalties will prevent a full measure of commitment to her profession. It is true that women do practice fewer hours, in part because they are substantially more likely to hold salaried, fixed-time positions. The 70% of women in medicine who are married tend to measure their success as the sum of many activities rather than the single-minded pursuit of one. However, the professionally ambitious woman is handicapped by the stereotype promoted by the lesser ambitions of other female physicians: residency and employment practices continue to reflect a discrepancy in achievement expectation for men and women.[2]

The Decision to Enter Medicine

Why don't more women seek application to medical school? I remember my small, beleaguered son loudly proclaiming to an unbelieving nursery-school class: "My mommy is too a doctor — she's not a nurse." Medicine in America is seen as a masculine profession and there are few role models of achievement for women. The cultural values of passive, compliant behavior for women are at sharp contrast with the powerful, father-like role of the doctor. The girl who considers a career like medicine, involving a major commitment outside the home, will inevitably feel challenged about her femininity.[3] In a large survey by the Office of Program Planning and Evaluation of the National Institute of Health, women getting their bachelor's degrees and interested in medicine identified the major obstacles to their continuing on into graduate study in medicine as finances (42%) and family responsibilities (41%). Women are more reluctant to take out the loans for higher education, which will constitute a negative dowry and require repayment in the childbearing years. Thirty-three percent of the women surveyed said that their parents tended to discourage them from medicine and 27% felt that male physicians in general resented women colleagues. Approximately two-fifths of these women eventually did go on to enroll in medical school.[4]

The Medical School Years

The woman entering a predominantly male medical school often feels on trial and is embarrassed to seek needed counseling. Each must find a niche somewhere between aggressive competitiveness and the image of wide-eyed feminine naiveté. Fifteen percent of women medical students will leave some time before graduation, with the major dropout occurring in the first year. The greater risk is neither academic nor related to marriage; it seems more tied to the intangible factors of role stress. The female medical student with children may use the role model provided by her own mother to decide if dual commitment to career and family is feasible.[2] Entering the wards, the third year woman clinical clerk often finds she has entered a male club which may exclude her from social activities and segregate her on-call room to a distant building. Relationships with peers and instructors vary from warm acceptance to hostility, but the woman medical student is never allowed the luxury of anonymity. I remember assisting at a 2 a.m. delivery on a clerkship, when the obstetrician suddenly asked if I was married. I indicated that I was the wife of another student at the same school and he loudly responded, "Well, why don't you quit — you got what you came for."

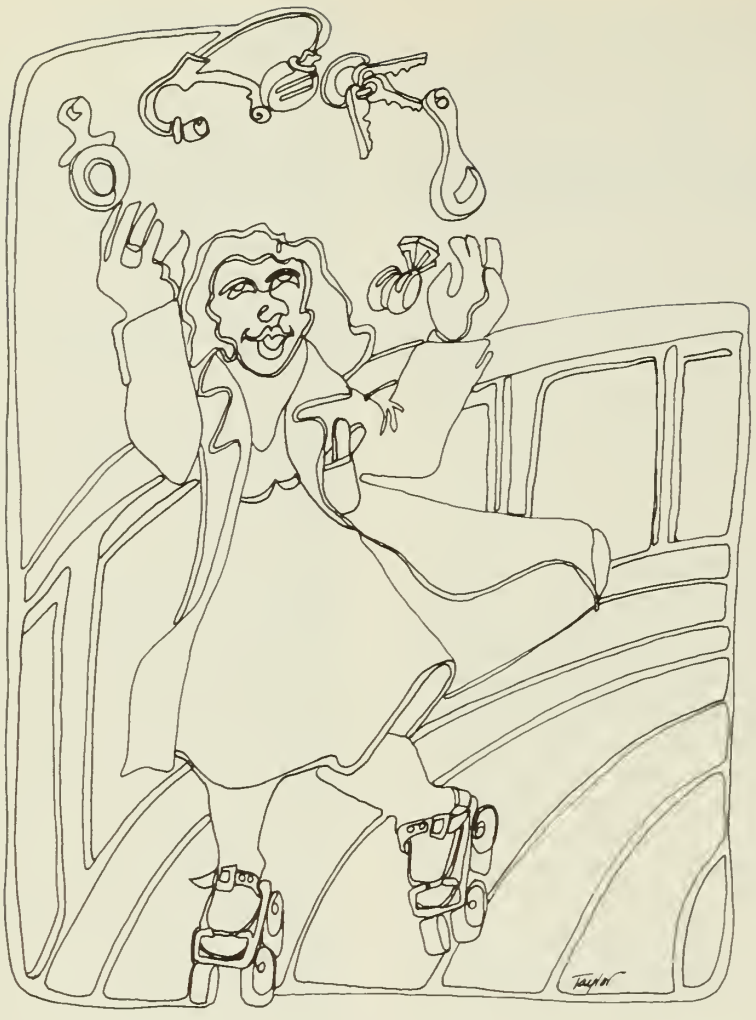
Most commonly, the clinical years are seen as a positive experience by the women students who welcome the shift from a competitive student to a caretaking physician role. Out of the turmoil of medical school, women students slowly evolve a sense of self as both woman and physician:

It is impressive to see how many women do not recognize the pressures under which they operate and the compromises which they have made and continue to make. They feel guilty about making any demands on a profession that has been "generous" enough to accept them. Women often accept the "peculiarity" of their position as doctors, and they may share the prejudices of men in regard to their capabilities and the legitimacy of their career aspirations. The essential harmony between "feminine" role expectations and the caretaking activities of medicine is often ignored.[5]

Patterns of Internship and Residency

The choice of internship and possible residency heightens the role stress for women. Internship is the most strenuous and inflexible experience of all the years of medical training. During this period, many women feel they must work particularly hard to gain acceptance, but they dread the image of "castrating bitch," which may result.[6] The single woman in the internship year is particularly anxious to prove her femininity as well as her competency. The physical demands take a particularly heavy toll on the married woman and those dependent upon her. I recall two incredible months when my husband was on a daily 4 p.m. to midnight emergency room rotation and I was doing an every other night on, 6 a.m.-6 p.m. medical rotation. After a night of no sleep, it was impossible for me to stay up until 1 a.m. to warmly greet him; he in turn was sound asleep as I awakened at 5:30 a.m. We knew of each other's continued existence because of the evidence of a sleeping body in the bed, but little else! Coveted weekends had to be bought by being on-and-up on Thursday and Friday nights, so it was small wonder that they rarely fulfilled the emotional expectations of two bleary-eyed lovers. The feminine identity issues at home were combined with professional identity questions at work; my new patients often asked, "Oh, are you a student nurse?" The last straw came when I was food-shopping for the weekend after 48 sleepless hours. Still in my "whites," I was asked by a woman shopper to weigh her vegetables, because it seemed obvious to her that I was the produce assistant.

The stresses are many but they are countered by the growing realization of professional competence and respect. Role models are eagerly sought out to discuss the balancing of responsible physicianhood with an acceptable lifestyle. It is particularly important that women be a visible and available resource in any medical facility. Residency training programs do offer a few alternatives to full-time commitments, most often in the "feminine specialties" of pediatrics and psychiatry. Some of the opposition to these programs has come from women themselves: "The



best way to get women discriminated against is to offer them the 'privilege' of a watered-down program."[2] Yet the potential talents of a women are not fully used if her chosen specialty training requires such a pattern of martyrdom that it encourages her withdrawal. I recognize that the directors of residency programs have often been left in the lurch by women forced to leave by a husband's job change or by their own pregnancy. Out of such pressures come statements such as that made on the design of psychiatry residency programs in a study by Dr. Morton Weinstein.

In the case of the program with enough applications from acceptable male candidates, the results show that mental health manpower needs would be better served by the appointment of an all male resident staff. The development of special programs for women residents and the active recruitment of women (who would displace men at such a center) would not appear wise or warranted.[7]

The harshness of policy statements may, however, be softened in practice. I served a year of residency including a nine month pregnancy at Dr. Weinstein's nstitutions and found that I was able individually to work out a program suited to my obvious needs. In turn, I feel that their flexibility has been substantially paid back by my contributions as a faculty member. The balancing of responsibilities is difficult and I still feel a residual guilt for the inability to meet all of my training commitments because of intervening family needs. The years of stress do take a toll and the pursuit of excellence is increasingly weighed against the need to provide adequate emotional support for the family. For many women physicians, readiness to accept salaried positions and diminished interest in the rigors of board certification are two natural outgrowths of this conflict.

The Childbearing Years

If the woman physician chooses to have children, she is faced with both motivational and practical problems. There are real health hazards for the fetuses of practicing women physicians who may be exposed to toxins, radiation and infection. The pregnancy of a woman doctor can evoke strong emotional responses in both patients.[8] and staff.[9] When the child is born, the mother-physician who totally stays home is at greatest risk of never returning to her profession. The bombardment of knowledge in the medical profession is so overwhelming that the woman who cuts all ties may find it almost impossible to reenter the mainstream. Advocates of institutionalizing the "retraining" model for women must consider that their plan bears the risk of encouraging this most difficult path. On the other hand, the demands of small children and home responsibilities must be met and can only be partially filled by household help and day-care centers even under the best of circumstances.

The picture that now emerges is of a marvelous juggling act, both exhilarating and exhausting, of multiple roles and commitments. This situation, not unique to women physicians, is impressively chronicled by Rhona and Robert Rapoport in their *Dual Career Families*.[10] There are special strains in multiple role cycling and the core identity of the woman professional can become increasingly fragmented as she becomes mother, mistress, hostess, cook, housekeeper and community worker. Consider this not atypical day in my life:

Cast of Characters: *Self*
Son, 6
Daughter, 3
Husband, academic medicine – teaching and research

WEDNESDAY

6:45 Everybody up; rush of dressing, breakfast, search for son's sneaker.

7:30 Husband takes son to school bus. Decide if daughter is recovered enough from chicken pox to return to nursery school. Yes. Call school. Call housekeeper to

tell her to pick daughter up after school.

7:45 Pile dishes. Take daughter to nursery school. Stop at bakery for bread.

8:30 Arrive at VA Hospital. Four phone messages. New medical students today. Orient, find two patients for them to see. Draft copy of memorandum to hospital director. Medical executive meeting. Interview residency applicant. Dictate note. Set up schedule for June meetings.

1:30 Leave work early for meeting with son's teacher about school placement next year. Agree to take white mouse for summer. Decline to bake cupcakes for room mothers' tea. Call husband to get mouse cage. Stop to pick out Father's Day present with son.

3:15 Arrive home. Housekeeper says mouse will attract field mice into house. Work downstairs on paper revision for an hour. Housekeeper leaves.

4:30 Play with kids. Start dinner. Wonder what to serve for daughter's birthday party on Saturday. Stop children's war over who gets to hold mouse.

5:30 Husband home. Drink and dinner in midst of bedlam. Phone call from physician sharing office for private practice about needed repairs.

6:30 Give daughter bath and read her story while husband cleans up kitchen. Explain again that monsters aren't real.

7:00 Put son to bed. Try to answer his question on how magnets work. Read Pinnochio.

7:30 Collapse. Read paper; talk to husband.

8:00 Work on paper revision; needs to be done by tomorrow. Wonder what to say for lecture to women's course at Medical Center.

9:30 Ready for bed. Sew on button. Put out children's clothes. Realize I have neglected to write to family and water garden again. Oh well . . .

The areas of possible strain are apparent — and the woman with the inner drive to become a physician is often the one who must feel successful at all she undertakes. One woman put it clearly: "I feel as if I'm always apologizing, either to my profession when I have to go home, or to other women who say, 'Oh, I couldn't leave my child.' "[2] Another physician said, "I feel as if I've submerged myself in a tunnel of obligations for ten to twenty years with little time to come up for air, but with the conviction that this is the most satisfying life that can be had."[2]

Good housekeepers are hard to come by, and when found, their very competence raises the competitive spectre of two mothers in the same house. I find the most difficult issue is not the physical balancing of multiple schedules but rather keeping the emotional responsiveness demanded by intimacy with one's family after a day of heavy work responsibilities. In my practice and social contacts, I am impressed by how many outwardly successful women are bothered by feelings of guilt and emptiness as they find there is nothing left to give. The ways of dealing with the conflict are as inventive as the women themselves and often include special family togetherness times as well as an occasional opportunity for total escape from responsibility for a few days.

The obvious challenges of a dual career marriage go along with some special opportunities. When both partners are capable of generating considerable income, both may be freed to take the work position that is the most interesting rather than the most lucrative. The relatively new concept of partnership in marriage seems to depend on having a husband who is successful in his own world, whatever he does.[2] The man must feel secure about his own masculinity to pitch in on household work or to tolerate a financially more productive wife. A recent survey by *Medical Economics* showed that significantly more of the female M.D.'s rated their marriages "very happy" and sex lives as "excellent" or "good" as compared to their male counterparts.[11] A plus mentioned by many of these women surveyed is the particularly close relationship with teenage children when parenting is a shared responsibility and independence an expected way of life.

I have dealt mostly with the hazards of physicianhood for women because I believe that those who choose this route today must be special to be able to maintain the competence demanded of them in all areas. The women who continue to bring the drive and creative ingenuity to these roles will also bring a unique contribution to their profession. In return, there must be more recognition of the inherent sex biases in medicine and some restructuring of training and work situations on an individual basis to utilize womens' role more effectively. Even now, however, for most women physicians the pride of accomplishment in all areas of their lives is worth the substantial price exacted by their reluctant profession.

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The Saturn's Rings Phenomenon

by Mary P. Rowe, Ph.D.

"Affirmative action" has made startlingly little difference to America's most prestigious universities when progress is measured in absolute terms. For some academic departments the *percentage* improvement is huge, often infinite, since, for example, the difference between no women and one woman is an "infinite" percentage increase. But in *absolute* terms we are moving very slowly in the country's top faculties. Recent studies, including one commissioned by HEW to look at medical education, have concluded that we need careful studies of the ambiance in education and employment, to see more clearly why affirmative action is so slow.

In my job, of course, I see many reasons for slowness. Some women and blacks are poorly prepared, or so ambivalent that they fail to do good work. Some men actively fight the law of the land to maintain illegal discriminatory practices. But in my job I also find another factor at work — a problem that does not lend itself to legal redress or to improvement in time of economic promise, and which occurs with frequency at the best and most humane of institutions. This problem — the minutiae of discrimination — appears to be a major distortion in education. It is formidable not least because of the pettiness of individual events and because there are no adequate individual solutions. Throughout the history of science we have found the importance of seemingly small events and things: rockets do not fly with grains of sand in the system, trauma wounds heal better without sand in the sutures.

I deal with dozens of complaints every week, of which nearly all are, practically speaking, not actionable. In my institution obviously illegal behavior is very rare and the administration gives short shrift to its perpetrators. Unconscious slights, harassment, exploitation, provision of poor service and psychiatric problems manifested in sexist and racist behavior are however rather common, in all institutions.

Unconscious Slights and Invisibility Problems

One becomes aware of one's invisibility slowly, because it happens only now and then and is difficult to identify. We say we are invisible when our name is mysteriously left off a list — the list of postdoctoral openings or of new faculty or of those with committee assignments or lab partners. There is a last minute luncheon; only the woman professor is not introduced. "I was the only woman on the committee that handled maternity benefits; they never asked me to speak." A study group is set up on inner-city family structures — without minority or female members.

These invisibility and other unconscious slights are difficult to handle. If it is only you who are addressed by your first name, are you sure it is sexism? How can you be sure your paper was turned down because of sexism? Maybe it was a poor paper. Is your office space more noisy only by accident? Imagine you are the only top administrator whose office is not in the main building. Can you protest when you do not believe an insult was intended — and besides there is not very much space? (And what does one do with unintended insults that are still insulting?) Imagine that a woman professional who was supposed to do a job for a certain department copped out, and now the department somehow simply does not seek out another woman, even though the subject matter directly concerns women. Do you describe to them what you think is going on? Sometimes one thinks it is not worth it to protest. And yet I remember so vividly the face of a black student who came back from his first class in biomedical statistics. An example given in this class had been the VD experiments in the South which used poor, black men, without informed consent and without proper treatment. This experiment, a longitudinal study, had been cited as a fine example of long-term research. The young black student was deeply bewildered and hurt. Was it important to protest?

Harassment, Exploitation, Provision of Poor Service

Harassment is not ordinarily actionable. It is the department head who says "if she is given tenure, I will see that she is so miserable that she goes." It is the teacher who refuses to learn a young woman's name or calls her by the name of someone else, or who calls a young black woman by his own cute nickname for her. It is the professor who systematically humiliates his female students about their appearance, or the department head who loads on extra work to prove a woman cannot succeed in that job or because he knows she will not refuse.

Dr. Mary P. Rowe is Special Assistant to the President and Chancellor for Women and Work at MIT where she also teaches . The examples of discrimination cited in this study are all real incidents in the lives of women and minority people in educational institutions in the Boston area. This article is excerpted from a speech entitled, "Saturn's Rings," (the formidable rings around Saturn being made up primarily of bits of sand and ice). Some of the informal curriculum for women and minorities in large educational institutions – the minutiae of discrimination – also are like grains of sand, which impede educational processes and good jobs for women and minorities.

Exploitation of certain kinds is common. The single black professor is asked to serve as a token on endless committees (not always the most important committees). A female graduate student works overtime nights and Sundays with disproportionately little recognition; sometimes, as we have seen, even providing the basic discovery for Nobel Prize research, but without appropriate status or remuneration (cf. *Science,* July 1975).

Poor service and inadequate support to women and blacks is equally prevalent. Women medical students may miss out on the informal teaching given by a male surgeon while scrubbing for an operation. A black lab employee who was asked if she was "going to get pregnant soon," when she discussed her plans to apply to medical school, was also told she was a "bitch with no right to quit, who could have a great career as a lab technician if she was 'really' tired of typing for the lab."

Psychological Difficulties with Sexist and Racist Manifestations

Many of the incidents reported to our office reflect serious psychological problems of some faculty and staff. A black student who came back from a lab in tears had been told, when she came in with a bad cold, "Chick, what you need is a hot, deep protein infusion!" One scientist wrote me, "Despite the fact that women may be even more qualified, I believe we should curtail the admissions of women; they will deter men from doing their best creative work." There was the black freshman, who came in after someone "jokingly" threatened him with a lynching. And the written reference given for a woman scientist which stated, "You can hire this woman for your lab if you want to, but I'd rather have her body than her mind."

There are the occasional men who expose themselves, who need to seduce women they see as competitive, who pick on handicapped women, who will lie to blacks and women, who deliberately try to arouse a woman's guilt or worry about her family or femininity, who will smilingly say to a woman student, "I believe the only interesting thing about you is between your legs."

What Damage Is Done By The Minutiae of Discrimination?

There is as yet no serious study of these micro-inequities, but one can suggest many hypotheses as to why such behavior, which of course happens in other forms to white males, may do disproportionate damage to women and minorities. I believe these inequities *do* cause serious damage or I would not label them a major barrier to equal opportunity. Micro-inequities cause damage in part because:

- They often lead to obviously illegal behavior. Thus overlooking or "seeing through" women and minorities is a habit that may well lead to overlooking the best-qualified (woman and/or black) for promotion, or to underpaying women and blacks.

- They are a kind of pain which cannot be predicted very well in any functional sense. That is, by and large, they occur in the *context* of merit, and of striving for excellence, but do not have anything predictably to *do* with excellence or merit; that is, of course, what makes them "inequities." As an intermittent, unpredictable reinforcement, however, they have peculiar power as a negative learning tool, (unpredictable, intermittent reinforcement being among the more powerful types of reinforcement).

- They take up time. Sorting out what is happening to one, dealing with one's pain and anger, takes time. Extra time also is demanded from many women and minority people to help others deal with pain caused by micro-inequities.

- They prevent better behavior from occuring in addition to the direct pain inflicted. If a secretary or graduate student is unreasonably overloaded with routine or personal work for a supervisor, the overloaded person may suffer a loss of self-esteem and may also be prevented from doing the kind of excellent work that qualifies one for promotion.

- They often originate with more powerful people against less powerful people. Since less powerful people by definition have less influence it is not hard to see why it is difficult to get rid of micro-aggressors in *general,* let alone specific individuals who happen to be the victim's own supervisor or advisor.

- They are petty in a world where redress by the less powerful may often seem heavy-handed. Unionization, going to court, even appeal to the president's office may seem extreme weapons which themselves have high costs. The perceived lack of *appropriate* degrees of redress helps perpetuate micro-aggressions. This is, incidentally, why our offices handle "inquiries" as well as "grievances," and why we are gently trying to make ourselves better known. This is also why we try to be of no "cost" or low "cost" to those who prove to have been victims, taking on ourselves the onus of redress rather than always requiring victims to suffer not only the pain of injury but the costs of redress.

- Micro-inequities grow in mad and infinite variety. One has to get up early in the morning to stay ahead of the proliferation of types, let alone the number of petty injuries. Thus most women and blacks find themselves occasionally fighting the last war rather than the present one.

- They may have a negative Pygmalion quality. That is, the expectation of poor performance, or the lack of expectation of good performance, may by itself do damage because students and employees have a strong tendency to do what is expected of them.

- They contribute to barriers between men and women and blacks and whites, which means that each group fails to understand what the other faces. The forms of sexism are so specific that men and woman are isolated from each other's experience; so also for the forms of racism. Cross-group communications are always slower and more difficult; cross-group judgments are harder to make well. Thus women and men, blacks and whites, may make errors about each other ranging from paranoia to an inability to hear any criticism against individuals of a different race or sex.

- They are often difficult to detect or be sure about. Frequent victims, like women and blacks, may constantly have to deal with emotions ranging from legitimate anger to paranoia. The experience of being uncertain

about whether one was insulted or put down, inevitably leads to some displaced and misplaced anger which in turn may anger innocent (or guilty) bystanders.

- They are often not *intentional* in any conscious or even unconscious way even when objective observers would agree that an injury really took place. We are all socialized to believe that *intent* to injure is an important part of injury, and it is certainly critical to our dealing with injuries at the hands of others. Faced with a micro-aggression, the victim may not be certain of the motives of the aggressor and may be unwilling to start a fight where none was meant. Under conditions of uncertainty about motives most victims are again in the position of sometimes not getting angry when they should (which perpetuates the injuries and may weaken the victim's self-image), or protesting sometimes when no injury was *consciously* intended even though it actually occurred. The latter situation may be salutary for all concerned, especially if the aggressor reacts by acknowledging an unconscious intent to injure. But sometimes the aggressor is totally unaware of aggressing, and he or she may respond with anger, feelings of betrayal, bewilderment or worse.

It is apparent that there is no easy way to turn off micro-inequities. In fact, traditionally white male environments may even exacerbate certain kinds of discriminatory behavior like the aggressive and humiliating telling of dirty jokes in a lab. Continued experience of destructive situations that cannot be improved can start unhappy cycles of behavior ranging from declining self-esteem (which makes one feel still less efficacious in changing the environment) to withdrawal, resignation, poor work, fantasies of violence, and so on. At the very least either it takes a lot of energy to deal with an environment perceived as hostile, or it takes a lot of energy to maintain one's level of denial. (I have known many men and women to struggle for days at a time with their profound anger at an apparently "petty" insult.)

Do micro-aggressions do more harm to women and minorities than to others?

The question is frequently raised whether micro-aggressions do not just "happen to everyone." Quite frequently I will talk with a professor who openly says, "I harass everybody, Mary. I don't discriminate." Here let me raise hypotheses as to why micro-aggressions might be worse for minorities and women than for the average white male.

The "general" harassment often takes specifically sexist or racist form when applied to women and minorities rather than being randomly applied, or appropriately focused on their work. Instead of saying to some average white male, "Your work on this experiment has been inexcusably sloppy; you'll

never make it that way!", the remark may come out, "My God, you think no better than my wife; go home and have babies!" Or, "That simply won't do; I don't know how we are to make up for the centuries of Southern schools that produced you!" Like the dripping of water, random drops do little damage; endless drops in one place can have profound effects.

Many women and minority people are socialized to respond disproportionately swiftly to disapproval. Parents have carefully taught most female and many black, Spanish and Indian children to cooperate rather than to compete, especially when they are with white males, and to be very sensitive to anger and criticism from white males. Conversely one can find many white males who were explicitly socialized to expect hard knocks, to compete ferociously and openly even when injured, and to have a very high pain threshold in the first place. It would be hard to prove that either kind of socialization is "right" or "wrong" in absolute terms, but it is easy to see how these two cultural paths run afoul of each other. If a white male professor shouts angrily for five minutes at a young woman, she may not wholly "recover" from the attack for weeks or months or years. Later, in a discussion with the professor however, one may hear that he's forgotten his "random grouchiness" or thought it was trivial. Thus, behavior that might be trivial or survivable for the modal white male may be quite destructive to minorities and females in a manner that has nothing directly to do with the work at hand.

Just as it is hard for victims to put a stop to micro-aggression, in a traditionally white male atmosphere, it may also be harder for *bystanders* to stop certain kinds of micro-inequities because the slights are so normal that they simply are not noticed. Many white male professors are acutely uncomfortable around black and male secretaries and ignore them or fail to look at and address them — but do not notice it and neither do bystanders. Traditional pornography on walls, traditionally sexist jokes, and the use of sex in ads and announcements is so ubiquitous that probably most men do not consciously recognize them or may even add to them happily. Thus while some *general* forms of harassment and difficulty may be stopped by bystanders, some racist and/or sexist behavior may be overlooked in some departments because it is so "normal."

There is a more acute role-modeling problem for women and blacks with respect to their witnessing micro-inequities against others like themselves. That is, disproportionately more women and minorities see people "like them" put down or ignored or ill-served by their superiors and elders. This point may be clearer when one remembers that the principal same-race and same-sex role models for minority and female students are clerical workers and hourly workers, those groups most frequently reporting micro-inequities.

It may be harder for blacks and women to find mentors to help them deal with micro-inequities. Because there are so few minorities and women, in high level positions, other minority and female members of the community cannot, on the average, find the same amount of high-status, same-race or same-sex mentorship that white males can find. Sometimes the higher-status blacks and women try to compensate by spending extra time as same-race and same-sex mentors, but get deeply tired.

Sometimes there is also a peculiar difficulty in finding an *appropriate* mentor when one has been the victim of a racist or sexist micro-aggression. If one goes to a white male, he may or may not understand. If one goes to a same-race, same-sex friend and/or mentor, he or she may be just wonderful in helping one to deal with it or may be of no help at all. That is, listeners of the same race and sex may be so discouraged and angry, or so full of denial, that they are worse than useless. I believe therefore that it may often be more difficult for minorities and women to find adequate help in dealing with the minutiae of racism and sexism than for average members of the community to deal with "general inhumanities."

Many women and minority students and employees have a disproportionate need for supportive white male mentorship and are disproportionately injured when a white male advisor or teacher or supervisor assigned to them is just generally inhuman. Let us take an example, Susie Hernandez who is a student. She needs someone to advise her about getting ahead in our white male environment because it is foreign to her. She may not be getting much support from Spanish-speaking people at home because she is living a non-traditional life. She is less well supported by the general society and may be less well supported by her family than if she were a white male. If her assigned advisor turns out to be just generally inattentive, gruff and cold, she has been deprived of a needed, positive mentor in circumstances where she needed assistance probably more than the modal white male student. The situation will be compounded if she is afraid to ask for a new advisor or does not know how to find substitute help.

Therefore there are many reasons why the problem of micro-inequities for minorities and women goes beyond the *general* inhumanities of large organizations. The point may be clearer if you will imagine being a solo, young, white, male, child care worker in a large, conservative, inner-city day care system. The "general harassment" might include sincere questions and snide comments on your sexuality. Other white males might find you odd. Blacks and females might distrust your skills. You might *be* in fact inept in some ways your first year. You might be very sensitive to the just run-of-the-mill anger from your cross-sex, cross-race supervisor. You might find the constant assumption that women-are-better to be very oppressive — the ads, the jokes, the pictures on the walls, the fathers deprived of custody. You might have no one like yourself to turn to. You might get to hate always being asked to fix things and being asked by visitors why you are there.

Micro-inequities are a sad by-product of situations where anyone is functioning in a non-traditional environment. They probably cause more pain for non-traditional members of any community than for traditional members. I believe the minutiae of racism and sexism constitute formidable barriers to advancement for minorities and women. Invisibly, harassment, exploitation, poor service and deep seated psychological problems of a racist and sexist nature all create special difficulties in educational institutions. These patterns must be recognized and seen in perspective in order to cope with them well.

Where There is a Will, There is a Way

by Deborah W. Miller

The dilemma confronting many women physicians has been how to balance and integrate the duality of two roles — the traditional wife/mother and the dedicated doctor — without sacrificing one for the other. In the past, the low numbers of women, first in medical school and then in the hospitals, contributed to a willingness to work out special needs without asking that these institutions make any concessions on their behalf. When women physicians were sparse, imitating men's unflinching commitment to medicine while not forsaking husband and home turned these women into virtual superwomen. Skeptical male colleagues will insinuate that it is fine for there to be women in medicine as long as they take everything like a man. Male physicians of an older generation are not accustomed to working with women colleagues. Women physicians constitute a more numerous segment of all physicians today, but they are far from being fully accepted by their confreres.

Women currently in medical school who anticipate being married and having children while they are young (according to the statistics, women should have their first babies preferably by age 30) believe that raising children and practicing medicine are not inimical concerns. What they no doubt will face in their quest for flexible postgraduate training is that an extended rite of passage — of young people putting in all the hours that their elders did — is de rigeur. If you do not, your commitment is suspect. And if you are a woman, you are proof positive that women do not have the stamina or dedication to be good physicians.

Marian Woolston Catlin '55, Lesley Bunim Heafitz '65, and Jean Emans '70 are all dynamic women, and to all of them, being a mother is as important as being a physician. The pattern for achieving a workable combination is different for each of the three, as is her outlook. Interestingly enough, these women are married to physicians. Each of their husbands has been an important source of encouragement and support for his wife's ambitions in medicine.

Marian Woolston Catlin '55, mother of Laura, 15; Jennifer, 14; and Randy, 9, did her basic psychiatry residency after Medical School, and has spent the past sixteen years caring for and raising her family. She is now a child psychiatry resident at Metropolitan State Hospital. "You can't be a full tilt mommy of little ones and physician in early training dealing with very disturbed children. I wanted to be a good mother and now I hope to be a good doctor." Lesley Bunim Heafitz '65, mother of Betsy, 8½; Joseph, 7½; Avrum, 6; and Sally, 4½, had her first baby after half a year of residency at Boston City Hospital and did not finish training until three babies later. She is now in private pediatric practice in her hometown of Melrose, Massachusetts. She has taken the written part of the boards and is waiting to get practice time for eligibility for the orals. "It was a full-time job being a mother when they were young. I'm very glad that I went back and finished. I had always said to myself I would." Jean Emans '70, mother of Matthew 1½, waited until the completion of her residency before she became pregnant. She is now assistant chief of the adolescent unit at Children's Hospital Medical Center. One of the reasons that she chose outpatient care was that she did not want to have to be in the hospital every day. "I'm not sure that men and women should be treated equally. In some ways it's very nice to be treated differently. Men cannot nurse babies or have them. . . ."

Undeniably, the major thrust for part-time or flexible residencies has come from women who want to continue their postgraduate training while not necessarily having to postpone their families. A committee from Children's and a subcommittee of the medical area Joint Committee on the Status of Women together have worked out a proposal for Children's: two people working three-quarters time (approximately sixty-five hours) for three-quarters credit and half the pay. The hospital would still provide each individual full fringe benefits and vacation time. Dr. Emans, who is on the committee, expounds: "All the people involved in a flexible residency would have to be there Monday through Fri-

Jean Emans '70

day. You indeed cannot take care of patients on a ward coming in Monday, Wednesday, and Friday. . . . Provisions have to be built into the system in advance so that other residents do not become jealous." Legally, such a program must be offered to men as well as women, and the proposal does so.

Dr. Mary Ellen Avery, head of the pediatric department at Children's, believes that women may become "second class citizens" by availing themselves of special privileges. "There's a backlash now and it's going to get worse if we do anything other than try to be fair to both groups in terms of doing things that are special." She firmly asserts that Children's will alter the internship and residency programs to fit individual needs or if it is the only way that a woman can train. But this is quite hypothetical because out of the four to five hundred applicants every year only sixteen are chosen, and none have as yet requested a flexibly scheduled residency similar in hours to the proposal's.

An outpatient residency was begun at Children's in 1963 which, while not limited to women, was filled by them. The hospital discontinued this program because of the dichotomy between outpatient and inpatient work, unaware that these residencies — with less strenuous hours and even though less than optimal — were the only alternative for women with young children who wanted to complete their training. Several people did their residencies part time, although the program was not set up that way purposely. Dr. Lesley Heafitz, who had four small children at the time, applied to Children's in March 1972 for a part-time residency, but found that outpatient work was inadequate for her. She worked two and a half days per week for half the credit, but as it turned out, for no pay. Even though she recalls having probably written on her application form that the pay did not matter, she says that they "would not have done that to a guy who was trying to support a family. It was just that I was in a unique position in having a husband who could support us." It was not due to her working part time that she was not paid because other women on a part-time basis were salaried; Children's had offered her the position on a volunteer basis as the budgeted amount for residents' salaries had already been expended.

Dr. Heafitz stayed at Children's for four months and was promised a salary if she remained, but she left because of the money situation and because "except for the specialty clinics, I wasn't learning or doing that much. I needed inpatient experience." Dr. Heafitz already had outpatient experience from the eight months she spent in a pediatric practice on her own, a mere two years after graduating from Harvard. She decided that when she went back — even with four children — she would "go full time and get it all over with." In the fall of that same year, she returned to finish her residency at Boston City Hospital where she had first been almost five years before.

Lesley Bunim Heafitz '65

Commuting from Melrose to Boston, being on every third night, leaving four children in the hands of a less than ideal housekeeper/surrogate mother, were each alone enough to wear down resistance; together, they were just about formidable. After completing her residency at Boston City, receiving excellent recommendations, Dr. Heafitz obtained a fellowship in neonatology at the Boston Hospital for Women. The first year, the embryonic research project to which only she had been assigned mushroomed into "the biggest thing since the respirator," but its magnitude was not recognized by those in charge. Her ebullience, however, belies her stoicism. When she was near the verge of faltering, she would never let it be known, for fallibility did not mean human fallibility, but the pejorative reaction from male colleagues and superiors that she "can't do this because she's a woman."

"My last year in the fellowship, having fulfilled my clinical responsibilities, I knew that I was not able to give the same kind of time to research and to reading homework. When I went home at night, that had to be the end of the job except for on-call duties. There was some time that had to be the family's. I was not doing what the guys were, but I was never going to say, 'look, it's just too much for me.' Because I knew the minute I did, that would just cut off opportunities for other women."

Focusing on family first and after that, medicine, was the only alternative that Marian Woolston Catlin could live with. Her choice was to be wife and mother for an unspecified number of years, which ended up as sixteen. "I feel so

Marian Woolston Catlin '55

intensely about medicine that I don't take it lightly," she stresses. "I don't want to be just a doctor. I want to be a *good* doctor. That's why I don't do it part time." Her equanimity about starting a child psychiatry residency at 44 may be the result of having finished her basic psychiatry residency before marriage — at least that part of her training was firmly rooted.

In addition to two years at Massachusetts Mental Health Center, Dr. Catlin spent six months as the one full-time physician for three dozen girls at the Children's Unit of Metropolitan State Hospital. Despite the time-consuming and responsible work, the program was not accredited then. She has now returned there to become certified in child psychiatry, having made absolutely sure that she will receive nothing less than full credit. "That means I work a full day, and night duty, emergency duty, and weekend call. Out there it's an active duty. It would not be worth it unless I got qualified. Unless and until you punch that necessary full-time hole, you don't get credit."

In the late 1950s there were a number of young mothers doing part-time outpatient residencies at Mass. Mental Health. According to Dr. Catlin, who was then working full time, many of these women found themselves having to cope with too many demands. "I know they were not full members of the clinical staff. They weren't regarded in quite the same way and I don't think they were able to get quite so much out of their training experience. They missed part of the total input. In order to have a full satisfaction and understanding, you really have to get all that multidimensional input. Much of it has to do with just being there. The system wasn't geared to these women. They were fighting an uphill struggle."

"Half-time training possibilities have always been dear to my heart," says Dr. Catlin. "Even though they were not for me, I was always concerned about working for them for other women." About two years ago she returned to Harvard to do just that — but her experience was a mixed one. As an assistant to Dr. Mary Howell, former associate dean of students, she was to test the workability of half-time house officerships. They and a coterie of female medical students from Harvard had planned to discuss the concept of flexible residencies with various clinical directors, who, believes Dr. Catlin, "given time and a little leeway, will make it possible for you to get trained." The meeting times the students suggested were either 7:30 or 8:30 a.m. or 7:30 p.m. — precisely the times Dr. Catlin had set aside to be with her own children. "They could not see what they were doing. They were asking me to be there at just the times when a part-time resident would need to be at home."

Regardless of whether women with families will be able to work out flexible residencies or will have to tolerate full-time ones, the problem of child care is imperative. Drs. Emans, Heafitz, and Catlin all have to rely on household help. "I probably spend one-third of my salary on the housekeeper," asserts Dr. Emans, "but it's worth it for peace of mind." Besides the cost, some women now feel that it is incompatible with their values and lifestyles to employ a housekeeper. Other options are day care or boarding the child with a mother who stays home with her own children. Another alternative is having a student or student couple live in, and perform household chores and care for preschool age children. Many physicians and pediatricians believe that day care for an infant is not good. According to Dr. Emans, most women in medicine are making a good enough income so that they are unwilling to put a young child in an environment that is not optimal.

While Dr. Emans sympathizes with women who want to raise their children and practice medicine simultaneously, the problem for her is academic — she waited until after her residency was over to have a first child. Her internship and residency at Children's followed a conventional sequence. She says that the resistance to the proposal to establish part-time residencies there is the same, "as the kind of resistance we met when we wanted to go from every other night to every third night. 'You won't know your patients.' 'You can't become a good doctor unless you're with your patients twenty-four hours a day.' But you learn a great deal realizing that you can't be at the bedside of your patient all the time. That's not the way life is. The assumption was when they went from every other night to every third night that we would be ruined; that you wouldn't learn anything." The objections ceased after that method was adopted — mainly because the clinical directors were convinced by the actuality of the new system.

Dr. Emans and Matthew, 1½

Flexible scheduling can be more easily integrated into a small program. An exponent of this is Dr. Robert Masland, chief of the adolescent outpatient unit at Children's and in charge of four fellows every year. He made it possible for Dr. Emans — while she was a fellow in the program and now that she is his associate — to work a three and a half to four day week so that she can spend some time with her young son. Dr. Masland strongly supports the idea of flexible residencies: "Having special consideration doesn't lessen their commitment to medicine. I go by the quality of the performance. Jean has a special arrangement, but there are no complaints because everyone sees how hard she works. I think it ought to be spelled out that everybody gets this kind of treatment."

A discernible trend indicates that younger men not only advocate flexible residencies for women, but believe that this type of residency has merit for men too, who are now more inclined towards actively wanting to participate in their children's upbringing. To counter the criticism of some physicians that young people are unable to "postpone gratification," Dr. Masland responds: "The older generation doesn't understand this and maybe never will, but I think this could be a very helpful thing for the present generation — to have the concept that you really do need some time off during your training years, and not wait until you're too old to really enjoy it."

William Clark '65, who has been working at the Cambridge Hospital for five years, found that "most of my creative energy was going into my professional life and I was not sure that I wanted it all to go there." Formerly director of the hospital's alcoholism program, he decided to "step back from working full time because I couldn't get an adequate perspective on the rest of my life." Dr. Clark still works with the alcoholism program, but since July, in a different capacity and for fewer hours each day. There has been no adverse reaction from the hospital or professional colleagues. The motivation came out of a need to develop his "other sides" — sports, music, and reading — as fully as he had his physician side.

A typical pattern emerges when two medical students marry. They want their internships to be in the same city, and may be fortunate enough to have it work out that way. This was true for Dr. Emans and her husband. They married after their first year at Harvard and graduated in 1970; both wanted to stay in Boston — she in pediatrics at Children's and he in surgery at the Peter Bent Brigham. Dr. Masland, however, perceives that often the decision is the man's and the woman, even a strongly opinionated woman, will yield — believing that next time the choice will be hers. "I have the feeling these guys are going to put them off," he sighs. "She's going to make more of a sacrifice." This sense of futility encompassed Dr. Heafitz when she was working on her fellowship at the BHW and feeling estranged from her children. Her husband is a thoracic surgeon in a group practice in Medford, and she knew that they could not move closer to the Medical School. "The man rules where you go. I have to go where he goes."

Dr. Heafitz and Betsy, 8½, Sally, 4½, Avrum, 6½, and Joseph, 7½

Through sheer determination, Dr. Heafitz did complete her training, and constantly struggled not to compromise her family. She found herself expected to do everything. "I try to do everything, but I really can't. It's very, very hard. On the surface it looks like I'm doing it, but the frustrations all came out at home. During my training it was very tense especially with my husband, although it wasn't his fault. He did a tremendous amount, but not without objecting." Her husband is extremely proud that she is setting up a pediatric practice and has helped with its details. Yet it takes concerted effort to recognize that a professional wife cannot be home all day as can a traditional wife.

For two years Dr. Heafitz had "stayed home doing nothing, but felt guilty. I tried being Mrs. Suburban Housewife — it was not for me." She found that the League of Women Voters held no allure, and that she was considered different from other women in Melrose. Her professional status, moreover, made her an easy target of frustrated suburban women's hostility. "I love my family, my children, but I'm not happy staying home doing nothing, and I'm not happy being away full time. I like dealing with patients. I like being a doctor."

Such strains were more successfully avoided by Dr. Catlin who can only immerse herself "baptismal style" in any one undertaking. She had done everything in its proper sequence and had been highly goal-directed at "all the right places:" prep school, Vassar at 16, Harvard Medical School at 20, pediatric training at Children's, residency at Mass. Mental Health — "but I knew the internal damage it did. It took me sixteen years to catch my breath. I was tired of jumping all the hurdles early." Although it was of her own volition that Dr. Catlin did not practice medicine during this period — devoting

Dr. Catlin and Randy, 9, Laura, 15, and Jennifer, 14

her energies to family responsibilities — she remained at home partially to accommodate her husband's change of specialty at age 35 from neurosurgery as a flight surgeon to a first year psychiatry resident who was on call himself every other night.

Unlike Dr. Heafitz, Dr. Catlin derived satisfaction from her numerous volunteer projects and let her creative outlets of painting, gardening, and designing "recharge" her. The volunteer work that she did for schools, often in a quasi-medical capacity, buttressed her confidence about going into a child psychiatry residency at this later stage in her life. She is familiar with current problems and eventually wants to work in the field of learning disabilities, which is now coming into its own. "People I can take. That doesn't bother me at all. It's just all those technical things that I'm supposed to know that I'm going to have to pull to the forefront."

She maintained her ties with medicine through reading, attendance at seminars, and her husband's ongoing analytic training and later professional involvements. In any specialty that requires manual techniques, such as surgery, pediatrics, and medicine, assimilating someone who has been on the periphery for a solid leave of absence is costly. It may be that in psychiatry, a long-term hiatus can be absorbed without extensive re-education and retraining.

A more intractable problem, in the view of some, is the discontinuity of patient care that may result from less than full-time training or practice. Speaking as pediatrician-in-chief at Children's Hospital, Dr. Avery opposes flexible residencies being substituted for the norm. She concedes that people can practice nine to five medicine, but not on a hospitalized patient who needs continuity of care. Dr. William Clark, whose own schedule at Cambridge Hospital is now part time, does not deny that continuity of care is an integral problem that will have to be solved. Disrupting patient care is "not a necessary consequence," according to him. "It is necessary that we work out systems that make it possible. In general, I think it is a good idea for men and women . . . I'm glad that women have led the way." Men choosing flexible residencies might legitimize them in the eyes of older physicians — but, quips Dr. Heafitz "Until the old school gets phased out, there will be equal discrimination."

Specialties that appeal to women often appeal to men for similar reasons. Dr. Masland freely admits that he chose academic pediatrics because it afforded him more time with his family; most of his evenings and weekends are free. Emergency medicine is also attracting men who can no longer live with the image of the doctor being on call twenty-four hours a day. "Of course," says Dr. Emans, "the ideal person the director is looking for is going to spend twenty-seven hours a day at the hospital."

Even if that was attainable, would it make an exemplary physician? According to Elbert Magoon '73, who has recently completed his internship at Children's, "There is nothing magic in working 120 hours compared to half that. Spending time on anything — whether with your family or in research — adds another dimension. It doesn't detract from the practice of medicine."

For a woman, medicine ought not preclude motherhood; however, medical students who believe that if there is a will there is a way, may have to rethink the triple threat of medicine, marriage, and motherhood while still in training. Women who can speak from experience are the best source of counsel. Drs. Emans, Heafitz, and Catlin all know the hardships involved in trying to give equal time to medicine and family. Dr. Emans and her husband were able to sustain each other through their residencies. For her, a flexible residency would not have been desirable — she "wanted flexibility later." For Dr. Heafitz and Dr. Catlin, the goal of completing their training came belatedly — each one of them opting for a different method of family rearing. Dr. Catlin has always been happy with her decision of taking time off for her family. Dr. Heafitz's candid opinion now is, "If I had it to do over again I would have put off my family entirely until I finished."

By the time the Class of 1949 (HMS's first coeducational class) celebrates its fiftieth reunion, hopefully women in medicine will be commonplace, and both men and women will be raising families and treating patients, aided by implicit knowledge and explicit reinforcement that it is not an either/or proposition. The rising number of women students at Harvard Medical School will exert a strong push for changing the current structure. As Dr. Heafitz declared, "Not that they weren't sympathetic to me, but they'll have to be more sympathetic."

Portraits of Physicians' Wives in Fiction

by Charlotte Goodman, Ph.D.

In Joyce Carol Oates's recent novel, *Wonderland,* a medical student asserts that "everyone knew that women were mad for doctors and for their money, and for their skilled practiced hands." Certainly many of the young women at the women's college I attended twenty years ago considered it particularly fortunate to become engaged to a medical student or young doctor, for as a doctor's wife one would be guaranteed economic security and a position of respect within the community that normally accrues to the doctor and his spouse. Furthermore, the word "doctor" conjured up images of idealism and heroism. Although few of my classmates in that pre-women's lib era dreamed of becoming doctors themselves, the idea of participating vicariously in the medical career of one's husband and of helping him to succeed had great appeal.

Through the study of literature young women may acquire a more realistic picture of the life of a doctor's wife, for good fiction can provide valuable insights about human nature and society. Writers like Flaubert, George Eliot, Charlotte Perkins Gilman, Sinclair Lewis, and F. Scott Fitzgerald had interesting things to say about the wives of physicians. More recently, Joyce Carol Oates, Doris Lessing, and Erica Jong have also written novels in which the protagonist is the wife of a physician. The fictional wives are usually depicted as unhappy, lonely, and unfulfilled, while their physician husbands are shown to be singularly lacking in compassion and understanding concerning their wives' frustrations.

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One of the classic descriptions of the marital problems of a physician and his wife is that of Lydgate and Rosamond in George Eliot's novel, *Middlemarch.* Lydgate has high professional aspirations, but his understanding of human beings is much more limited than his understanding of medical principles. Lydgate, who George Eliot tells us felt that "books were stuff and life was stupid," chooses as a wife the beautiful Rosamond Vincy, a spoiled daughter of a small town businessman. The author observes that Lydgate's "spots of commonness lay in the complexions of his prejudices . . . that distinctions of mind which belonged to his intellectual ardour did not penetrate his feeling and judgment about furniture or women. . ."

His belief that a wife "ought to produce the effect of exquisite music" leads him to marry a woman whose values ultimately force him to compromise his aspirations to do "good small work for Middlemarch and great work for the world." Lydgate discovers that the cost of being married to Rosamond, who he hopes will be an "adornment" to his life, is higher than he had anticipated: his debts rapidly mount, and he is finally forced to leave Middlemarch. In the final chapter of the novel George Eliot tells us that he had acquired a lucrative practice but that he always regarded himself as a failure. When I first read *Middlemarch* many years ago, I saw Rosamond as the ogre and Lydgate as her victim. It is obvious that Lydgate sees himself in these terms. He refers to Rosamond as a "basil plant," and he explains that "basil was a plant which had flourished wonderfully on a dead man's brains." I have since come to see that Rosamond, though she is not very likeable, remains true to her nature. Lydgate, who "held it one of the prettiest attitudes of the feminine mind to adore a man's preeminence without too precise a knowledge of what it consisted in," should not have been surprised when Rosamond failed to show an interest in his medical experiments. "Poor Lydgate! Or shall I say, Poor Rosamond!" George Elliot writes, each lived in a world of which the other knew nothing."

Another physician whose career is adversely affected by his marriage is Dick Diver, a psychiatrist in F. Scott Fitzgerald's *Tender Is The Night.* Despite the fact that his medical colleagues warn him of the hazards of marrying a psychiatric patient, Diver is attracted to the beautiful and rich Nicole Warren, a patient in the elegant European clinic where he is working. Diver at first is lured by the prospect of a life of luxury and ease that his marriage to Nicole will afford him, as he finds the domestic situation of his dedicated associate Franz, a physician of modest means, lacks "grace and adventure." However, he and Nicole become so enmeshed in social commitments that his goal of becoming "a good psychologist — maybe the greatest one that ever lived" eludes him. He finds that "goods and money" have begun to occupy almost all of his time and that his wife's large income "seemed to belittle his work." At the end of the novel, Nicole has left him, and we are told that Diver returns to America where he practices in one small town after another, and is perpetually working on "an important treatise on some medical subject, almost in process of completion."

It is common knowledge that F. Scott Fitzgerald wrote his own conflicts with his wife Zelda into *Tender Is The Night,* in which he placed most of the blame for the dissipation of his talents on his wife. For a view of Zelda's side of the story, one should turn to Zelda's own novel, *Save Me The Waltz,* in which it is the husband who destroys the wife. In Fitzgerald's novel we see Nicole mostly

through Dick Diver's consciousness, but even Diver, who blames his destruction on her, ultimately sees that a doctor-patient relationship is hardly a sound basis for a marriage. The weak and dependent Nicole feels that "she had not existed for a long time." When she believes that she is cured, she leaves Dick. Fitzgerald writes, "Her ego began blooming like a great rich rose," and she now "resented places where she had played planet to Dick's sun."

In both *Middlemarch* and *Tender Is The Night* it is the physician who is destroyed by his wife. However, in the remaining fictional works that I will consider, the converse is true: the narrator of Charlotte Perkins Gilman's haunting story, "The Yellow Wallpaper," becomes psychotic; while Emma Bovary, Carol Kennicott in Sinclair Lewis's *Main Street,* Marie Pedersen and Helene Vogel in Joyce Carol Oates's *Wonderland,* and Kate Brown in Doris Lessing's *The Summer Before the Dark* all become profoundly depressed by their roles as the wives of physicians.

"John is a physician, and *perhaps* — (I would not say it to a living soul, of course) . . . *perhaps* that is one reason I do not get well faster," the depressed writer-narrator of Charlotte Perkins Gilman's "The Yellow Wallpaper" says, and she explains, "You see, he does not believe I am sick! and what can one do?" Although she describes her husband John as "very careful and loving," she also says "John is away all day and evening and even some nights when the case is serious." He "scoffs openly at any talk of things not to be felt and thought and put down in figures," while she enjoys speaking of the beauty of gardens on a summer's evening. She feels it would do her good to be able to write, but John absolutely forbids her to work until she is well again. "It is so discouraging not to have any advice and companionship about my work," she says. Her husband cautions her to use her will and good sense to check her tendency towards fantasizing because for someone with her "imaginative power and habit of story-making, a nervous weakness is sure to lead to all manner of excited fancies."

Deprived of the paper on which she can write, the narrator becomes increasingly obsessed with the wallpaper in her room, seeing in it a creeping figure of a woman confined behind bars. As her depression and psychosis deepens, she herself becomes the figure who has escaped from behind bars. She tells her husband, "I've got out at last!" In madness she has escaped from her husband, who has deprecated her story-making faculty, forbidden her to write, criticized her lack of self-control, and called her fears of madness "a false and foolish fancy."

Like the narrator of "The Yellow Wallpaper," Emma Bovary in Flaubert's *Madame Bovary* feels impotent and confined. Longing to escape from dull country life, she is attracted to Charles Bovary, a physician. After she marries him, however, she finds him to be dull, hardworking, and rather inept — a provincial doctor who "taught nothing, knew nothing, wished nothing," instead of a man who would "excel in manifold activities, initiate you into the energies of passion, the refinements of life, all the mysteries." Bored and dissatisfied, Emma hopes for a male child through whom she will have revenge for all her impotence; instead, she gives birth to a girl who will be "always hampered" as women are. Through her liaisons with a gentleman from a neighboring estate and a clerk from her town, she seeks the adventure and romance that her marriage has failed to provide, but she is deserted by the former and piles up ruinous debts in her pursuit of the latter. Finally, she dreams of a release from suffering through a heroic death; however, she dies a horrible death from the poison she has taken.

The American counterpart of Madame Bovary is Carol Kennicott in Sinclair Lewis's *Main Street.* Carol's husband Will, a dedicated physician in a small midwestern town, is more affable and attractive than the dull-witted Charles Bovary, but he cannot share in Carol's imaginative life any better than did Charles Bovary in the life of the day-dreaming Emma. Carol feels stifled by the provincialism of Will's beloved Gopher Prairie. Her attempts to make Will like poetry, to have him take a trip to New York with her, to encourage him to speak with her about his medical cases, all end in failure. Carol sees herself and Will as belonging to separate races of people who will never understand each other. "His calls mine 'neurotic;' mine calls his 'stupid,' " she thinks. As her coldness towards him increases, Will begins to see that perhaps his wife should have been an artist or a writer instead of the wife of a small town doctor, but he maintains that once she had decided to come to Gopher Prairie, she should have stuck to her decision and made the best of it.

When Carol disagrees with Will about a political issue and he calls her and the "long-haired men and short-haired women" who share her point of view

"seditious," she finally decides to leave him. However, after she and her young son spend two years in Washington, she returns to Will and Gopher Prairie. Sinclair Lewis does not suggest, however, that Carol will now settle down to happy domesticity, for at the novel's end she is angered again by the town's conservatism. When her husband says to her, "Don't you ever get tired of fretting and stewing and experimenting?" she replies, "I haven't even started."

Though they are intellectually limited, Charles Bovary and Will Kennicott are portrayed as genuinely devoted to their respective wives. This is not true either of Dr. Pedersen or Dr. Jessie Vogel in Joyce Carol Oates's *Wonderland*. Both are portrayed as domineering, egotistical individuals who shatter the lives of their wives and children. The sole function of Dr. Pedersen's obese wife seems to be to help the cook prepare the Rabelaisian lunches for her overweight husband when he comes home from his clinic. Those familiar with Oates's writing know what nightmare qualities everyday objects take on in her work. So it is with the food that Marie Pedersen prepares; it comes to symbolize the superfluousness of her existence. Despite the diamonds that sparkle on her fingers, it is obvious that there is little difference between her and the servant who assists her in the kitchen. In a memorable scene, Mrs. Pedersen turns the pages of a family album. She sees herself, "upper arms fleshing out like sausages," standing behind a table laden with baked goods for a church bake sale. Then she turns to clippings and photographs of Dr. Pedersen receiving honors for his great accomplishments as a diagnostician and leading citizen. "In his patients' eyes he can do no wrong," one caption reads.

Jesse, the adopted son of the Pedersens, discovers that his stepmother occasionally gets drunk. One day she asks him to drive her to the city (Dr. Pedersen has discouraged her attempts to get a driver's license), and she confides to Jesse that she has decided for her own survival to leave her autocratic husband who does not permit her to contradict him even about the bringing up of their children. She says to Jesse, "Men don't understand, they don't see that I am a human being of my own." She relates to Jesse that Dr. Pedersen married her because her father and her uncle were doctors who had money and land. Describing her "crazy" husband's desire to "save everyone from dying" and to be "famous in every country of the world," she says bitterly, "There are things that don't appear in the news stories about Dr. Pedersen." Marie Pedersen's rebellion is short-lived, however, for shortly after her conversation with Jesse, her husband appears and takes her back home.

Like his stepfather, Jesse marries the daughter of a physician. One of the main reasons Jesse is attracted to Helen Cady is that her father is a winner of the Nobel Prize. Helene herself is said to have been a brilliant student in chemistry at Harvard, but when she marries Jesse during his internship she only works part time in the chemistry department of the University of Chicago, and she gives up her job soon after she becomes pregnant. Although Helene never complains of her loneli-

ness and bitterness like the other constantly complaining interns' wives, she hates being pregnant and feels more and more that neither Jesse nor her physician father seem to listen to her. On one occasion she imagines calling her father and screaming at him:

I am Helene Cady. What has happened to me? I was supposed to grow up into a certain person, but where is that person? I've waited for years and nothing has happened, marriage hasn't made any difference . . . and now my life is over, I can't tell myself that it will happen in the future . . . I am everything, now, at this moment, that I will ever be. It's over.

Motherhood does not make Helene feel more fulfilled, and she begins to feel more and more that she is being "annihilated" by her husband. Joyce Carol Oates writes, "He could not imagine her, had not the time to imagine her existence, and so he was destroying her."

Less bitter towards her physician husband, but bitter nevertheless about her situation, is Kate Brown, the protagonist of Doris Lessing's moving recent novel, *The Summer Before The Dark.* Kate, the middle-aged wife of a British neurologist, discovers that "nothing had 'happened' to her for a long time; and she could look forward to nothing much but a dwindling away from full household activity into getting old." While her husband Michael is at the height of his career, she has reached that stage in life when with her four children just about grown she feels "unnecessary." Though she thinks it "would have been mad not to marry, mad to choose Romance Languages and Literature over being Michael's wife," she is panicked when he leaves to spend several months doing research in the United States, and her children all leave home for the summer. A strong, independent woman, Kate resists saying to her family, "I am like a cripple or an invalid, after years of being your servant, your doormat. Now help me." She also resists confiding her feelings to her husband: "it's as if he listens to something such a long way off it has nothing to do with him." During the course of the novel Kate takes a job that she finds unsatisfying, travels to Spain, has a brief affair with a younger man, becomes very ill, and finally, after months of living in a rented room in the apartment of a Bohemian young girl, creeps back to the security of her own home. Doris Lessing's novel certainly cannot be said to have a "happy ending."

The one novel about a doctor's wife that ends on a more optimistic note is Erica Jong's *The Fear of Flying.* Perhaps the fact that it does is because the doctor's wife, who is also the novel's narrator, is the least conventional of the women I have described. A writer and teacher who is married to an American-Chinese psychiatrist, the narrator begins by telling the reader that something seemed very wrong in her marriage. "Our lives ran parallel like railroad tracks. Bennett spent his day at his office, his hospital, his analyst, and then the evening at his office again, usually until nine or ten. My teaching schedule was light, the writing exhausting, and by the time Bennett came home, I was ready to go out and break loose." Resenting her husband's inability or unwillingness to communicate with her, she says, "Doctors always use their work as an excuse for not being human." After a brief affair with an unconventional British psychiatrist whom she meets at a psychiatric convention in Vienna that she is attending with her husband, she reaches the conclusion that perhaps it is neither marriage nor her husband that is at fault but rather the fact that she has been unrealistic in her expectations of what marriage should provide for one's emotional sustenance. Of course, she is still young and has the prospects of a successful career as a writer before her. One cannot help but wonder what her point of view about her marriage will be twenty years later.

One exception to the description of unhappy doctors' wives is Sinclair Lewis's heroine, Leora, in *Arrowsmith.* Leora Tozer seemingly is supposed to represent the ideal wife of a physician. Before he meets Leora, Martin Arrowsmith, a medical student from a poor family, is engaged to Madeline Fox, a socially prominent university student. When Martin berates those medical students who "just want to get the knowledge that'll enable them to cash in," Madeline reminds him that it is important to be practical. Fortunately for him, Martin marries the more idealistic Leora and is able to pursue his career without compromising his own ideals. Comparing herself to Madeline, the self-abnegating Leora says,

Perhaps you like me better because you can bully me – because I tag after you and she never would. And I know your work is more important to you than I am . . .

Leora, who has "a genius for keeping out of his way and for not demanding to be noticed," uncomplainingly encourages him, first when he is a country doctor, and later when he begins to work in a research laboratory. She sees herself as "a lazy, useless, ignorant scut," whose only life is to see that her husband is comfortable. Like the patient and silent wife of Martin's mentor, the brilliant scientist Max Gottleib, Leora never makes demands on Martin that interfere with his own desires.

Yet even marriage to a paragon of virtue like Leora has its drawbacks. Martin cannot help feeling guilty about neglecting her as he returns to the lab and leaves her alone night after night. Though Sinclair Lewis pulls out all the stops when he describes Leora's death from plague on the island to which she has insisted on accompanying her husband, I sense that when Leora dies, Martin Arrowsmith is released from an intolerable burden of guilt.

To what extent are these fictional wives typical of the wives of real physicians? Are the problems of the wives of physicians different from those of the wives of other busy professionals? To what extent are the wives themselves responsible for their own unhappiness? I am aware that writers of fiction find it more interesting to write about unhappy individuals than happy ones, but it is certainly remarkable that so many first-rate writers have chosen the unhappy wives of physicians as their subject. A physician's wife myself, I do not think all physicians' wives would agree with the authors of an article that appeared in *McCall's* in 1969 entitled, "Never Marry A Doctor." However, I do think that many of these fictional portraits have some validity for both physicians and women planning to marry physicians — as a warning of the difficulties they may encounter. For those wives or ex-wives of physicians who have experienced some of the problems depicted, these works should have the value of showing them that in their frustrations and feelings of depression or anxiety they are not alone.

Reflections After Thirty-five Years

by Olivia Ross

These are the thirty-five year old facts and fancies from the distaff side. Fifty-two percent of the intrepid wives of HMS '39 answered a questionnaire designed to ask, for the first time, how they evaluated their lives as doctors' wives. Their responses had a special brand of honesty and good humor. We accept no blame for the following collation due to a preponderance of individualistic response. (Data is based on 52% of the 125 questionnaires sent out.)

Our average age is 53.5 years. Most admitted to their birthdays which range from 40-69 years. We are about as married as we can be according to national statistics. Of our four divorces, two have chosen to take another chance with a doctor. Three are widows.

It seems that the best time to marry a man during his medical career depends on personal preference. When asked at what stage *we* married, there was a distinct corollary between the best time to do it, and when we did it. Our advice to the next generation ranged from "adequate financial support" to "when you can't live without each other." We had two marriages after (his) college graduation. Most married during internship, followed by residency, "in-practice" and medical school. By marrying into an established practice, did we miss some of his earlier challenges and relationships? Forty-two percent of HMS '74 students are married. Eight percent of HMS '39 were married.

Here is our ranking for the leading sources of satisfaction in our lives as doctors' wives: a congenial marriage, intellectual companionship, economic security, enjoyment of *'his'* professional friends, respect in the community, his professional dedication, the humorous side of his practice, learning by osmosis, and being a doctor, too!

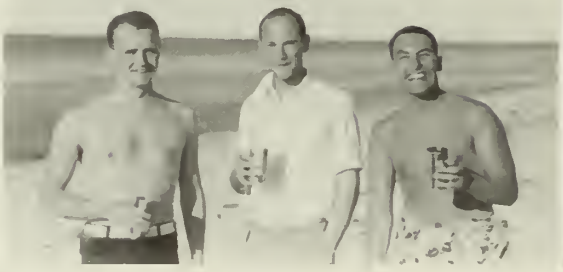
In sound-off section, our frustrations as doctors' wives were: canceling plans at the last minute, making decisions alone concerning family health, discipline, and finances, irregular hours and telephone calls at home, loneliness, lack of sharing in his professional problems, his health, the diminishing doctor's image, misconceptions of non-professional people, unpaid patient bills, should he be waited on at home as he is in the hospital? medical meetings as vacation, and keeping the soup hot while he's assaulting the peaks!

No one felt martyred, but we agreed there were periods in our marriages when our children lacked fathering: 46% said yes, 24% said no, 27% said occasionally, and 3% had no answer.

Our new babies grew older waiting to meet their hardworking fathers. Supportive interest increased as the load decreased for both father and child! We did compare our lack of fathering to non-professional men who work late and travel a lot. But weeks went by when we resembled "two ships passing in the night." It was a challenge!

Eighty-two percent responded negatively when asked if there was another career they wished their husband might have chosen. Eight were too aghast to respond. Four percent opted for a less death oriented branch of medicine or a group practice. Six percent thought of banking, politics or a college professorship. Ninety-four of our husbands had not entertained the thought of another career, according to us. Of the 24% of our class "mates" who were depended on, to some degree, for professional assistance, 20% said it was a contribution to their marriage, 4% felt it was a threat and decided to go home or pursue another career. All felt they gained an awareness of the pressures and patient problems from the experience.

This is an abridged version of the Class of 1939's Wives' Report, put together by Mrs. Olivia Ross, wife of Frederick Ross '39, chairman of his class's 1974 thirty-fifth reunion.



Clockwise, from left to right: Francis Moore '39 donned a grass skirt for the Aesculapian Show of that year; Donald Matson '39 and Alexander Bill '39, new president of the alumni association, cavorted in the show too; Frederick P. Ross '39 and an unidentified young woman at the Nu Sigma Nu dance in May 1937; Frederick P. Ross '39, Walter Kemp '39, and James Geiger '39, at the final picnic at Crane's Beach before graduation; John "Pup" Adams '39 hard at work at the Peter Bent Brigham in 1940; and on the previous page, the wedding day of the author of this article, April 16, 1942.

Our childrens' careers have a healthy divergence, from doctors and lawyers to cab driving, construction, and finding oneself. Eighty percent of our children are married, 10% are divorced, 7% are too young, 3% are not presently considering it. Our children are both mavericks and squares. But, "the apples didn't fall very far from the tree." Remarkably, 50% of our children have chosen to emulate our lifestyle. Twenty-four percent chose not to, 13% are not "jelled" yet, and 13% did not answer. Mostly, we share the same values and goals. The majority of our children are combining career and traditional marriage patterns. Familiarly, they are trying to earn enough money for life's comforts. Then, some like doing as they please. Forty-five percent of us prefer our own lifestyle to our childrens', 4% don't know yet, and 14% did not answer. Thirty-five percent would emulate their freedom of dress and conformity, but forego blue-jeans 24 hours a day. We like their assumption that their jobs have no gender, whether career or cleaning. There is less concern for "rainy day," freer individual expression, and an innate democracy due perhaps to a greater awareness.

More than half of us believe we could support ourselves if necessary. Some would need a refresher course. Judging by the 24% who said "just barely," there is some question concerning the standard to which they have become accustomed (age barrier was of small consequence). One felt she might be a great cleaning lady! Seventeen of us presently are employed in a variety of professions.

Thirty-six percent of us have our own separate interests. Gourmet cooking topped the list, followed by a variety of things related to the arts and crafts area, reading, group therapy and the history and culture of China (20 years). What are our favorite personal indulgences? As far and wide as urges spread, there are favorite indulgences to go with them. Some expensive, some cheap, some internally or externally stimulated. Our addictions run the gamut of: reading in the tub, clothes, candy, bowling, auctions and antiquing, taking a taxi, gin, dining out in high style, ice cream and movies, buying books, crewel, painting-water coloring (uninterrupted), expensive bath oil, arts and crafts, long distance phone calls to children and friends, housekeeper, botany field trips, occasional solitude, having hair done once a week, shopping for our home, croissants and coffee on a hotel balcony overlooking the sea, travel, golf, tennis and skiing — eased by apres activities, sex — and of course, Thompson Seedless Grapes. Can you believe that three don't know or wouldn't tell?

Sixty percent of the class approved of the admission of 46 girls (28% of the class) to HMS this year. Twenty percent did not, 16% wondered, and 4% had no answer. The nays questioned their commitment and motivation and possible drop-out factor. They preferred the traditional role of the wife at home with children — and questioned if they were taking the place of a non-pregnant male. The yeas, on the other hand, felt that no discrimination should be present regarding sex and in fact, many people relate better to a female physician.

A few of us are proud that we still prefer a four-wheel drive to a Cadillac.

Doing Women's Work

by Gwen Frankfeldt

The Joint Committee on the Status of Women was formed in 1973. The Faculty voted to approve the formation of a formal committee charged with the responsibility to review and recommend improvements in the status of women at the Schools of Medicine, Dental Medicine, and Public Health, and the Joint Committee began functioning that summer. The Committee has twenty-six members, drawn from employees, faculty, and students from the three schools and house officers in affiliated hospitals. In addition, there is a system of task forces, involving about 150 people, which bring recommendations to the Committee. This fall, the Joint Committee will be issuing its second report on its accomplishments, plans, and work in progress, with sections on employees, faculty, students, and house officers. Meetings of both the task forces and the central committee are run democratically and are always open to visitors and potential new members. Anyone interested in participating can reach the Committee at 734-3300, extension 2162, Monday through Thursday.

Representatives from the Joint Committee participating in this interview are: Eileen Shapiro, coordinator of the Committee; Shirley Driscoll, M.D., chairperson of the Committee and professor of pathology at HMS (Boston Hospital for Women); Ann Barnes, M.D., assistant professor of gynecology and obstetrics at HMS (Massachusetts General Hospital); Susan Bear, a Medical School employee in surgical research; and Maria Savoia HMS '76.

"It's great to know I'm not alone"

Q: *The Joint Committee on the Status of Women has been in existence for two years now. How would you describe the role it has been playing for women here and for the medical area community in general?*

AB: This is a very male-dominated atmosphere, and for one thing, I think we serve a consciousness-raising function for women here. Communication has been one of the big successes for the faculty task force. Women in all aspects of the Medical School have found that there are other women with the same problems, and even if it is just moral support, it is a communication system that has never existed before.

MS: We say to women that their concerns are legitimate; that yes, what they are feeling and thinking is okay; that there are others who feel the same way.

ES: There were some interesting effects resulting from the student task force's report on sex discrimination, that the *Alumni Bulletin* covered last February. Dean Ebert agreed to distribute this to the faculty, and I think the Committee owes him great thanks for being willing to say to faculty, this is important, look at it. It opened up the eyes of a lot of men about what they were doing, and, more important, moved them to talk to women and say, *"Does this bother you?"* There have been a significant number of faculty who have made an effort to be sensitive to the needs of their students, and in particular their women students, and it has worked out well on both sides. We have gotten some terrific letters from men, saying that they read the report, and at first they thought, "It's trivial," and then they thought about it, and said, "You know, I've done all these things. And if it's bothering students and I'm not teaching them as effectively as I could be, maybe I should reconsider my teaching methods."

In a subsequent questionnaire, we asked women students for their reactions to the report. One of the comments that came in over and over again, unsolicited, was: "It's great to know that I'm not alone." If you are the one minority person in a group — whether you are the one woman, the one black person, the one male, or the one white person, it's an alienating and lonely experience sometimes; but what's more important — and I think this refers to women in administration when there is only one — there is no one to back you up in what you say. So I think that that report gave support to women.

Progress has been made

ES: Another way in which we have made progress is that, through the Committee's efforts, there are now many more faculty women involved in decision-making groups. All new search committees in the medical area now have women on them, and that was no small feat. I think that, after our persistence, President Bok felt that this was indeed a wise way of getting women involved in the selection process. And all standing committees of the faculty also now have women members, which was not true two years

ago. It is a small step in one way, but a tremendous one in another. First of all, it means that women will not be in a passive position as to the policies of the Medical School. The other thing is that women — like any politically naive group — need experience in administrative structures.

The Schools of Public Health and Dental Medicine

Q: *Among the Medical School, the Dental School, and the School of Public Health, is there any differential in the amount of progress?*

ES: The problems in the three schools are different. The dental school should be commended, because there are only two per cent women in dentistry now, and they have made a conscious effort to have fifty per cent women in their classes. There are obviously very few women dentists that you can choose to be faculty; so they are attacking the problem at the bottom. In medicine, where there are about ten per cent women, the problem is being approached differently, and the real need is for effective affirmative action for academic appointments. Public health really has a different history as well. There have traditionally been more women in public health, and a lot of the discrimination in public health seems to be M.D.'s versus non-M.D.'s — but that is also changing.

Consequences of affirmative action

AB: In terms of specific goals, in the area of affirmative action, it has been slow going at Harvard, as it has been everywhere. The state of the economy and all the other things that slow down affirmative action have affected us too.

ES: There has been quite a bit of research on affirmative action recently, and while it has been shown to have some effectiveness, it has not given women and minorities the edge that a lot of people think that they have. And what is happening commonly now is that many women feel that they should be getting positions by the bucketfuls because women are in demand; while the increase nationally in women faculty in the past several years has been only something like from twenty-two to twenty-four per cent. One of the things that concerns me is that women and minority individuals, particularly those seeking academic or high level administrative positions, often feel, "There must be something wrong with me, because I'm having a lot of difficulty finding a job or getting promoted, and here's affirmative action. This is supposed to be the time when we have it made, and it seems to be extremely difficult." In fact it *is* extremely difficult. Discrimination is still encountered, although affirmative action has made some progress.

People feel women are getting preferential treatment, which is not what affirmative action says. It only says you must recruit, actively, for women and minority candidates, and then choose the best candidate. After recruiting widely, if the best candidate is a white male, that is who you hire. The only time preference comes in is if you have two equally qualified candidates — one female and one male, or one black and one white — then you must choose the person who has been discriminated against in the past.

A need for role models

MS: The situation is difficult because we need good role models for younger women, and in order to really get anywhere, you need people at the top. But there has been so much discrimination in

Eileen Shapiro

Maria Savoia '76

Ann Barnes, M.D.

medicine for so long, that there are relatively few women at the top right now; and there are relatively few women who are in a position to be at the top.

ES: And that is definitely perceived as a need by students. We have just done a study in which we asked all women students at the Medical School to rank thirteen activities of the Committee in order of importance. The one that consistently came out on top was: more women faculty, more women advisors, more women tutors.

Lack of recognition

Q: *Do you mean to say that there are no women in decision-making positions?*

AB: No, in Building A and in other parts of the Medical School, there are women employees who *are* key in the administration and in the decision-making process, but who get no recognition, either financial or in their titles. They are being called secretaries when in fact they are administrative assistants of a rather high level, or administrators in fact. And the way they are treated in a social sense does not make their jobs look attractive to younger women. Some of these women have been here for many years, and it is only when their jobs open up and people hire secretaries in their place, that they find out that the person who had been working there was of a much different sort.

ES: It is unlikely that you would call a man doing the same work an administrative assistant; you would probably call him an administrator. This is a sort of institutional sexism. Once you call someone an administrative assistant, a lot of secretarial components come into the job description.

AB: We see this in the outlying hospitals where things are being organized and administrators for clinics are being hired, usually young men in place of the women who had been doing the work. These men come in as administrators at a five-figure salary that is about half again as big as the salaries of the women they replace.

ES: A lot of it is unconscious. There have been incidents where these administrative jobs have been advertised, and when a woman calls, she is asked if she can type. If a man calls, he is not, the assumption being that he will have a secretary. While this is not done maliciously, it has a malicious effect on women.

Employees in limbo

SB: This is one of the major issues that employees on the Committee are concerned about: proper job descriptions. That is the heart of the matter.

ES: The way the personnel system works, all the non-exempt employees, and supposedly in the future, all the exempt employees (exempt from overtime pay and generally considered more responsible positions), have a job title, which fits into a larger, generalized job description. The job title is slotted into a position level, which reflects responsibility, and is assigned a salary grade, which tells you what the salary range is.

SB: But in the exempt group, there are only seven existing job descriptions. So there are hundreds of people in the medical area who do a tremendous amount of work, who have responsibility, but who are not classified.

ES: It is a peculiar position to be in. Basically, the employee has no power to argue: "I have more responsibility than this generalized description," "I'm really something else," "My salary is inadequate," or "I'm making too much money," or whatever, because there are no standards. And you have no way of judging what someone in a comparable job is doing. It puts employees in limbo. These job descriptions were required in the initial writing of the affirmative action plan, and have recently been required — again — by HEW. Harvard's affirmative action plan says that this process has been started — and that was in 1972.

Educational benefits for employees

SB: One recommendation of ours that has been implemented is educational benefits for employees. We recommended to the deans of the three schools that a program be instituted whereby employees in the medical area could take courses here for credit at a very low fee. That was put into operation last year. The employees can take courses for credit at ten per cent of the normal tuition.

Susan Bear

Shirley Driscoll, M.D.

Day care prospects

Q: *What is the Committee doing about day care?*

ES: Day care is a critical issue, and one that requires an immense amount of organization. At one time it was proposed to the Medical School — it was never acted on — that a full-time coordinator be hired, and I think that is actually what is needed. We will try to form a task force on day care this year — possibly as a joint effort with Children's Hospital — which will try to make a proposal and get funding and a place for a day care center.

Q: *Are there other universities that have set up day care centers for their employees, faculty and students?*

ES: Yes, as a matter of fact, Harvard does in Cambridge. The University provides the space, makes the buildings suitable according to the standards of the Office for Children; then the parents or the day care organizers have to raise the money for the staff and for supplies. So the model is actually right across the river. They have a full time coordinator, and they have set up several centers.

Part time residencies

ES: On some of the student issues, some of our recommendations have had a tremendous response. The administration has given us terrific support and a lot of good advice and guidance on the issue of the establishment of part time residencies, on which the student task force has been working extremely hard. Several students and I have gone to Washington and have lobbied with Senators Kennedy and Javits to have an amendment added to the health manpower bill which would actually set up a certain number of part time residencies — what we are now calling reduced scheduled residencies — and Senator Kennedy has accepted that as part of his bill. This progress would have been impossible without the extremely strong support of Deans Ebert and Hiatt, and also of the Office of the Vice President for Community Affairs in Cambridge.

Grievance procedure a priority

Q: *What about another recommendation of the student task force — that a procedure be set up for resolution of grievances?*

ES: That rated extremely highly on the students' lists of priorities. The question still to be worked out is, do we want just a grievance procedure for students, or a procedure for faculty, students, and employees; and if so, do we want it individually by school, or do we want one medical area procedure.

The whys of specialty choice

ES: One of the things that we will be investigating this year is the question of why women choose the specialties that they do. On our recent questionnaire, we had an eighty per cent response rate among the fourth year women and a sixty per cent response rate among the fourth year men. An equal percentage of women and men went into primary care, but most of the women went into pediatrics, and most of the men went into internal medicine. The question that intrigues me is why does that happen; why don't you get a random distribution? When the women evaluated all of their rotations in terms of the atmosphere toward women, pediatrics got rated as excellent or good by all of them, and was at the top of the list; internal medicine was quite a bit lower; and surgery and obstetrics and gynecology were really at the bottom.

MS: The bottom of the barrel. In all fairness though, in some institutions that attitude really is changing. For instance at the Peter Bent Brigham, right now people are quite conscious that there are not many women in surgery; women are being much encouraged to look into surgery as a career.

ES: That was clear on the questionnaires; some women wrote that they had had superb experiences in surgery.

"A political question"

Q: *Have any of your views or concerns changed as a result of being on the Joint Committee — your priorities, or your opinions as to how easy or difficult certain things will be to achieve?*

MS: I think that when we first started to try to get the Committee established, we were very naive. We thought things would fall into place fairly easily. Many of us were not familiar with the workings of a bureaucracy; it was difficult, and we wanted to make changes faster than changes would come. We bulldozed on occasion, when that was not the appropriate tack to take.

Q: *Isn't that something that might be called a feminine characteristic — being afraid to "bulldoze?"*

ES: The question is, what tactic would be most effective? There are some things where you can get enough moral support that you can say, "This *must* be changed" — and other things where you have to go more slowly and build up a base of support until you get to a point where, regardless of whether people like what you are doing or not, they have got to do it. It's a political question; how are you politically effective. And if you want to kill a fly, you don't take a sledge hammer; you wait until you have an elephant.

MS: People often do not pay attention to you if you scream.

AB: Unless you have a thousand women standing behind you.

ES: But then you can usually say what you have to in a very soft voice.

A Critique of Pure Assimilation

by Karen E. Norberg '77

When professionals talk about "women and medicine" they usually speak of part-time residencies, admission statistics, and sexism in the lecture hall. That is, the conversations are about the problems of women professionals. Because students are still new to this world we also identify with the women who are *not* professionals, but whose lives are ruled more or less by the medical institutions.

Women medical students can feel some sisterhood with other women workers and consumers in the health system. In particular we are challenged by a growing women's health movement, persistent union drives among hospital and office workers, and the evolution of other community groups. Some women students are mothers, others live in Mission Hill (the working class community surrounding the medical area), many of us have been unskilled workers in hospitals, and all of us have had ob-gyn exams. The women's movement has taught us the value of personal support. For some of us the women's group is a way to keep in touch with, and be useful to, women in the world outside HMS.

Women from the first year class gathered names on a petition supporting Dr. Edelin, and to their happy surprise the whole class endorsed a statement to be read at a press conference of Boston women's groups.

Then there was the 1975 Conference on Women and Health. This conference was germinated by some women medical students, who worked with members of the women's health movement in Boston, and it quickly grew to involve 70 to 100 health workers, students, women from third-world communities, and other activists just in the planning.

Eventually about 2,000 women came from many parts of the US and Canada to participate in the broadest and most unwieldy such conference to date. The scope was impressive: there were workshops on occupational health for women workers, on organizing in hospitals, on the problems of third world communities, on diethyl stilbestrol, on organizing clinics for the United Farmworkers, on unnecessary surgery, on lesbian health, on childbirth . . . at least 120 topics. There were failures — very few working class women came — but for the medical students involved, it was a total immersion in the concerns and views of many (though not all!) women outside the professional island. An early leaflet announcing the conference said, optimistically: "By interaction and cooperation, women in the health care professions, women health care workers, and women in the community can make it possible for all women to reclaim control of their bodies and their health."

The *Bulletin*'s Line on Women, 1955-1975

We have perused the past twenty years of *Alumni Bulletin*s to see how women have been portrayed in our pages. The past has a way of catching up with the present, and often foreshadows it quite precisely, as we hope this collection of memorable excerpts will show.

In the **October 1955** *Alumni Bulletin*, Mildred F. Jefferson '51 wrote an acerbic letter to the editor regarding her experiences after graduation:

> I have become the unfortunate anachronism, the unwise one who did not follow the approved path to psychiatry, pediatrics, radiology and research. The rash one who chose general surgery. And after four difficult years in surgical training at a large Boston general hospital, I am blandly told, "Statistics show it does not pay to train a woman."
>
> Were the situation less tragic, it would be downright comical. Did it matter that this hospital had never had a woman in surgery before me and had no statistics whatsoever regarding the training of such? Did it matter that four long years had proved the fallacy of the old cry, "The training is too hard for girls?" Did it matter that my entire life has been directed toward one professional goal and that nothing short of serious illness or incapacitating injury could cause me to give up my profession? Not one whit.
>
> Few realize how devastating it is to be constantly reminded of the obstacles to one's progress by someone who is in an absolute position to remove the one then faced. Many have kindly offered to help me go far, far away, somewhere. And with genuine concern for my interests. But the lesson that Boston is the Hub of the Surgical Universe has been learned too well. I will not pass away.

In the **April 1956** HMAB, the wives of two fourth year medical students, Fran Menno and Joanne Lafferty, presented a wives' eye view. It was entitled "The Distaff Side."

> In the first year we find few of our wives fulfilling the wifely aspirations of homemaking and "child loving." Many more are using their talents to keep a roof overhead and soup on the shelf. Teaching as well as secretarial positions are high on the list of enterprises. There are many wives doing library work and some who are nurses and technicians. In the group of wives it is not hard to find those who are students themselves pursuing a separate endeavor. All are busy. Most are learning to squeeze the ironing and washing between dishes and meal planning before returning to the job that keeps all going. . . .
>
> All in all, both student and wife benefit from the rich cultural, social and academic atmosphere embodied in the close association of couples with each other, with the faculty and with other divisions of the University. . . .
>
> With commencement time drawing night, the fourth year wife looks back over the days she and her husband have shared at Harvard. Yes, there were lonely, blue moments, and problems too, but the joys outshine them all. She is happy that they came to Harvard where her husband received a superior education in medicine. . . .
>
> Inwardly, the medical wife feels a great deal of pride toward her husband's profession. It is a demanding position in life, but there is a definite place in it for her.

A message from the Harvard Medical area personnel office in **April 1957** asked alumni if there were "Any Plans for Your Daughter":

> Have you ever thought of sending your daughter to Harvard — where she will get a pay check — better than Dad ever received here?
>
> The Harvard School of Public Health, Harvard School of Dental Medicine, Harvard Medical School and its affiliated hospitals are searching for bright young offspring of bright parents to help staff research laboratories. The only requirement is a B.S. or a B.A. degree with chemistry and biology . . . (It is rumored that the personnel office brags about the record number of marriages between employees and graduate students — even the busy, harassed medical student has been known to be distracted by the glamour he meets in the hospital corridors, not to mention in the H.M.S. tunnel.)
>
> For those not planning a career in the basic sciences there are opportunities in the administrative offices of the schools and hospitals where intelligence and good typing are all the qualifications necessary.

A study on admissions by Curtis Prout '41 in the **October 1957** *Alumni Bulletin* was titled, "Has the Age of Giants Passed?" Findings on women nationally and at Harvard were that:

> . . . More women than men fail to graduate from medical school, and that one third less are engaged continually in the field of medicine (due principally to pregnancy or disability). Only 57% marry; those who do average 1.8 children. Granting the tentative nature of these findings, a comparison will show that the women graduates of Harvard Medical School are ahead of the national women doctors' average in marriage, childbearing, and utilization of their education. Their activities since graduation, however, conform to the national pattern for women doctors in respect to geographical distribution and division into specialties.

Vanderbilt Hall was opened to women students in the fall of 1958. An item in the *Bulletin*'s "Along the Perimeter" section from **October 1958** stated:

> . . . A reliable private source, in an oral poll, found 10-20% of the male student body to be strongly in favor of the new arrangement, 10-20% violently opposed and the rest apparently indifferent.

In that same issue, this letter to the editor came from a slightly nervous male third-year student (who wishes to remain anonymous):

> Girls are certainly seen often enough in Vanderbilt, and they are generally welcome. But none of them ever liked it so well before that they wanted to live there. At least, they seldom admitted it publicly. Few of the men could have been so bold as to issue the invitation. . . .
>
> . . . Many are concerned that the ladies may meet the first autumnal outburst of "Gaudeamus Igitur" in a flying wedge, bearing cookies and coca. Another possibility, and perhaps a more chilling one, is that in their efforts to become members of the gang some of the girls may try to join in the singing. Hardly anyone feels that the famous anthem will be improved by adding the *voce soprano.*
>
> Whatever the motivation may be, and whatever the outcome of the change, one thing is sure — medical education at Harvard is now as integrated as it can get . . . and it re-emphasizes the truth that so many of us have learned, "You can't live with women, but you can't live without them."

"An Open Letter of Protest to the Admissions Committee" sounds menacing. Actually, it was a sophisticated spoof, addressed to Kendall Emerson '33, dean of admissions, in the **February 1959** *Alumni Bulletin:*

> I wish to register a protest with the Admissions Committee, and have particular reference to a problem which is best summed up in Kitty Foster. . . .
>
> Intellectually she is miles ahead of her classmates. She is almost an authority on enzymes; she can take you around the Krebs cycle clockwise and counterclockwise. She seems to understand the intricacies of potential changes across the cell membrane, and she has read Malinovsky's papers in the original Russian. Now, she asks me to let her repeat his work in our lab this summer! It would be acceptable if this intellect were encased in a somewhat more humdrum human form, but here, in Kitty Foster, we have the intellect of an Einstein around which is molded the personality and form of a goddess, and it is this that makes her unbearable in the Department.
>
> . . . Her mind is razor sharp and a most fascinating instrument. Far be it from me to punish her because she is beautiful. But from now on, please pick minds in more ordinary garb. This is my plea.

That issue also contained the regular feature, "Diagnosis Deferred," which was given over to the various ways in which women started to converge on American medicine — starting with Elizabeth Blackwell who graduated from the Geneva Medical College in 1849. It was titled, "The Female of the Species" and mentions the efforts of individual women to gain admittance to Harvard. The School refused a $10,000 offer from Marian Hovey in 1878; nor did a supportive letter from Henry I. Bowditch '32 further the cause of Edith Varney's application a few years later. His letter of 1890 condemned Harvard's recalcitrant posture:

> I deem the position of Harvard in regard (to) the education of women, one of which *eventually* the University will be *thoroughly ashamed.*
>
> . . . The Corporation virtually says "You women shall not join in the Academic Rule because you are inferior to us; but as you want to learn something, we will have a small center connected with our University; an "Annex" and the professors, who choose to do so, are allowed to teach you in certain departments. But in this Department of Medicine in certain courses of which woman is fitter than man to practise the art — we will never teach you.
>
> Thank Heaven! other universities in this country and in Europe have higher ideals in regard to women.

The newly formed Radcliffe Institute for Independent Study was the topic of "Hope for Eddicated Wimmin" in the **Spring 1961** *Alumni Bulletin.* Its founder, Dr. Mary I. Bunting, wife of the late Henry Bunting '36, opined on medical education for women:

> The medical schools ought to seriously consider offering medical education to married women on a part-time basis, so that perhaps the M.D. would be an eight-year proposition, rather than a four," she suggests. In other areas, too, it is her hope that the responsibility will be met to salvage the nation's long-neglected talent, that of its highly educated women.

In the **Christmas 1961** *Alumni Bulletin,* Doris R. Bennett '49, Dorothy T. Clark '52, Raquel E. Cohen '49, Mary L. Efron '51, and M. Françoise Hall '57 reviewed the state of their personal and professional lives. Dr. Efron died in 1967, but the commentaries of the other four are summarized here, starting with Dr. Bennett:

> Now that I am practicing pediatrics my acceptance by colleagues and patients is quite complete. One of my

"Her mind is razor sharp . . ."

favorite patients is a four-year-old girl, whose pediatrician I have been since her birth. I referred her to a male ophthalmologist, whom she confounded by saying, when she saw him for the first time, "He can't be a doctor — he's a man."

Despite the usual exasperating and, at times, nerve-wracking aspects of pediatrics, I find the most gratifying relationship is with the mothers of my patients. I fear that in a majority of cases they have selected me as their pediatrician not because of my qualifications as a physician, but because I am a woman, a mother of two young children. They feel a sense of identification with me, and I with them. Not only can I tell them what to do in case of illness, prescribe medications, make diagnoses, etc., but I can tell them how I conquered certain problems in nursing, feeding, or washing diapers — helpful hints which carry authority because they come from both a doctor *and* a mother. Because of this empathy my patients are very considerate of me — rarely calling during the night or early in the morning because they know I have to get my children off to school.

In 1975, Dr. Doris Bennett adds this postscript:

Fifteen years ago I wrote a lighthearted article about the hectic but happy life I was leading trying to combine medicine, marriage, and motherhood. Now, as I look back upon my endeavors, I think I was not only lighthearted — I must have been light-headed as well. Only a chronic case of *Levitas cerebri*, the result of thirty years of intense brainwashing, could have made a person behave as I did then. In 1961 I was the brainwashed product of my culture's view of woman's place in society. Since I had chosen to enter a profession primarily reserved for men, my thirty previous years of cultural indoctrination caused me to feel that I therefore had to prove my femininity — I had to show that I was a woman. In the 1950-1960s my consciousness had not yet been raised. It never occurred to me that as a woman I deserved some liberation from the age-old mores which decreed that it was primarily my responsibility to maintain the home and raise the children. I went all-out to be the good wife and mother that I believed nature had meant me to be.

In addition, as a full-time practicing pediatrician I had office hours, saw hospital patients, made house-calls, and took phone calls. As I write this, I am amazed that neither my family, my home, nor my patients seemed to suffer. I do not feel that I was a hero mother-doctor-wife; in retrospect, I think I was just plain stupid. I have gradually become aware of a new concept of the woman as a professional person. A woman who invests just as much of her time, her money, her mind, and her soul in becoming a doctor as does her male counterpart should be able to realize an equal return on her investment; she should be able to experience the joys and responsibilities of marriage and parenthood equally with her male colleague — but not more equally.

To both husbands and wives the wife's professional involvement is often looked upon as more of an avocation. To one particular fellow-alumnus — the one to whom I am married — may I say, "Don't worry. I still have a fair amount of *Levitas cerebri et cordis*, for which a cure has yet to be found."

In 1961 Dr. Dorothy Clark was working:

Mondays, Wednesdays, and Thursdays as acting ward physician for the maximum-security, acutely disturbed ward in a psychiatric division of a large psychiatric hospital in Georgia. . . .

My patients are, of course, male and, although the only other women on the ward are secretaries and registered nurses, I have never experienced any difficulties with my colleagues because I am a woman. Recently, following a visit to our most disturbed wing with our consultant, he voiced a question often asked me: "Aren't you sometimes frightened on this ward?" My answer was negative. The other patients would always intervene for me as they have on several occasions, and this I find to be one of the benefits of being the female physician on a male ward.

Dr. Raquel Cohen wrote about herself this way:

What should I abstract from my rich life as wife, mother and psychiatrist? . . .

I have not been a "trail blazer" in the specialty of psychiatry; women have already made valuable contributions to this field. The natural endowments of a woman — potentially a wife and mother — enhance intuitive understanding and familiarity with emotional life. These qualities, coupled with the infantile needs of our psychotic patients, have made for an easier acceptance of women in this field. We share, of course, the other side of the coin; that is, the negative feelings patients harbor from their former relationships with women.

Her footnote fourteen years later is:

Basic changes have occurred in the "balancing act" of home, family and professional activities. The latter occupies the major part of my day — averaging ten to twelve hours, and the former have been receding as far as responsibility demands. My "parenting" role has slowly and painfully changed to a "friend" role and the housekeeping simplified into apartment dwelling.

Professionally, I have continued to pursue increasing opportunities to develop public health concepts in child mental health programs. I am heading a team of professionals at Judge Baker Guidance Center assisting the governmental agencies of the New England Region responsible to implement programs for Child Abuse and Neglect.

With the passage of the years I have been able to devote more time and energy to activities in the Medical School, participating in committee work and "trail-blazing" with my female colleagues through the activities of the Joint Committee on the Status of Women. When I read the statistics on the number of female students and listen to their expectations about how the facilities in the Medical School should be adapted to their needs, that first female group in '45 appears remote but very "gutsy" in my cross-generational memory.

At that time, Dr. Hall's third person autobiography told:

The "doctora" — the woman doctor — was very busy, but she was enjoying it. She was realizing herself. She was fulfilling the fondest dreams of the thirteen-year-old girl who had made up her mind to become a doctor. She was happy because not only was she a doctor but she was also making a special contribution because she was a woman doctor. . . .

How does all this mix with family life? If you ask Eric, 5 years old, you might get an answer in English, or Spanish, or French. If you ask Tefel, 1½ years old, you may not get any answer at all.

The sentiments of Thomas Wheeldon '18, in response to the previous exploration of "Harvard Women in Medicine" were formulated in his letter to the editor, which appeared in the **Winter '62** *Alumni Bulletin:*

It is my feeling that every doctor fortunate enough to graduate from this great institution must contribute something to the world in a medical way and this should be outstanding. With an average class of roughly 125, the investment in each of the careers is tremendous, and I now, as

I did originally, ponder the advisability of using a definitive percentage of this great undertaking toward medical students who are so easily written off.

I have a very brilliant daughter of my own, who declares that she is going to Harvard Medical School and devote her life to pediatrics. I doubt the advisability of the great investment of her admission to Harvard, even if this were a remote possibility.

Now Dr. Wheeldon's point of view is that:

While my attitude toward women being admitted to the Medical School may have relaxed a little over the years (we tend to mellow after 50 years in practice), I am still of the opinion that any graduate of Harvard Medical School should use the training to the fullest extent, and not on a part-time basis. Incidentally, I'm no 'old fogey' about this matter, and I'm all for the girls having an equal opportunity. So much so, that I sponsored one of the present female students at Harvard, of whom I'm very proud and shall hope and expect great things from her.

Old habits are not so easily shed, as the "Notice to Alumni Fathers of Sons Who Are Planning to Apply to Harvard Medical School" indicates. This gender reference was found in the **Fall 1964** issue of the *Alumni Bulletin,* almost twenty years after HMS began accepting applications from women.

Dr. Ruth B. Kundsin attacked the problem of "Where Are Our Women in Science" in the **Winter '65** *Alumni Bulletin.* Her observations ten years ago are still quite applicable today:

Americans have rigid notions as to what constitutes approved occupations for each sex. . . .

Other cultures do not, however, share this view. A brief visit to the Soviet Union last summer was an opportunity to observe their pattern of life. It was not unusual to see women engaged in occupations which we consider masculine . . . The presence of many women in prestige occupations and the complete acceptance of them were obvious characteristics of Soviet society . . . 75 per cent of practicing physicians were women. . . .

Fathers can and should urge their bright daughters to continue their education toward goals of self realization. Husbands can put up with the minor inconveniences associated with the working wife and revel in the greater fullness and joy in living that arises from a happy, independent woman who is utilizing her talents completely and arrives home with sparkling, challenging experiences of her own to tell and share. . . .

The woman currently working in science has met and overcome a mountain of obstacles. She has flouted convention in her goals and her training and continues to do so . . .

Mildred Jefferson '51 again contributed a letter to the editor in the **Spring 1965** *Alumni Bulletin* expanding on Dr. Kundsin's theories:

. . . Resistance to the advancement of women in science reflects a single facet of our brilliant established order. The unwritten law of American life is that advancement to the top levels is most deserved by those of proper background and this proper background excludes those of improper sex, race and social status. . . .

. . . The great eastern universities, with a few exceptions, and the renowned Boston hospitals, with fewer exceptions, remain complacent and aloof from social change. Appeals to fairness cannot reach them because they do not see that they are unjust. They are convinced that within their narrow limits they have found the best people possible. But, as long as their sampling remains nonrepresentative, of this they cannot be certain. . . .

My 1955 letter was an impassioned declaration of persistence from a depth of anguish, dismay and anger. My goal is still just beyond grasp. But my cause is just and I stand now as then — flexible but unyielding.

In 1975, Dr. Jefferson answers both this letter and her earlier one from 1955 — her efforts were not in vain:

Provident chance allotted me the role of pioneer in the line of Harvard Medical women who have gone into surgery. The cynic, observing that the time from the start of my internship to my certification as a general surgeon is the equivalent of three complete general surgical residencies, asks: would you do it again? My unqualified answer is yes.

It delights me to know that I have achieved one professional goal against the worst odds and that I have endured the most crushing of emotional sieges with no known permanent damage to my soul and spirit. I think, without rancor, of the unresponsive surgical chiefs of my past as pathetic poseurs of limited imagination and even less awareness and appreciation of human potential. But, I do not think of them often. So many people have helped me in so many ways that there is no value in remembering those who did not. My source of great pride is in the knowledge that I can help others similarly situated to avoid some of the difficulties I have overcome. That is the meaning of success to me.

In the **Fall 1965,** *Alumni Bulletin* an article was published on "Women Come 'Of Age,' " giving profiles of the ten women in the Class of 1969. An introduction stated that:

Ten outstanding women entered the Class of '69 and they represent nine per cent of their Class. They came with enthusiasm, but more than that, they came because they were eminently qualified to be here; they had chosen Harvard and, fortunately, Harvard chose them.

An event of the first magnitude took place at the November 1965 Alumni Council meeting, which was reported in the **Christmas 1965** *Alumni Bulletin*:

They made one decision, among others, that was unique and will undoubtedly delight alumni. Miss Dorothy Murphy, known to all as either Dot, Dottie or Dorothy, was made an honorary alumna . . . Miss Murphy is the first woman who is not an M.D., to receive the honor. . . .

. . . She received the ovation in her own way by borrowing James Jackson's hat, and with a flourish and a bow, she said: "After all these years, among so many men, I am happy to greet you on an equal basis!"

The **Spring 1969** issue of the *Alumni Bulletin* on "Women in Medicine" contained an article on "Admission of Women to HMS" by Dr. Helen S. Pittman, a member of the Admissions Committee, with insights on how women are affected by the selection process:

. . . they are considered on their individual merits as "applicants." I feel considerable confidence in making this assertion as it is based on my own experience. I have served under two chairmen: Kendall Emerson, Jr. '33 (September 1951 to June 1955) and Perry J. Culver '41 (since September 1955), and have now been party to the selection of eight classes.

The Admission Committee has no quotas of any sort. We have no preconceived idea of "type." . . .

. . . The interview is perhaps of special importance in the case of a woman applicant: they are not subject to the draft and they do marry and have children. We know that the woman is not trying to find a way out of military service, but what thought has she given to the reconciliation of her obligations to medicine, marriage, and family? . . .

The editorial in that issue, "Twenty Years Later," was authored by Doris R. Bennett '49, Raquel E. Cohen '49, and Iolanda E. Low '53. They discredited the reasons usually cited for conscious and unconscious discrimination of women who want to become physicians:

> Although it seems that HMS has been a good place for girls to go looking for husbands, the women have certainly not stopped with achievement of this goal . . . about 90 percent who matriculated at Harvard have remained active in some phase of the medical profession — in practice, community health, research, teaching, or some combination of these fields. This must compare favorably with statistics of the number of male graduates who remain active in medicine. . . .
>
> . . . It is ironic that not one Harvard Medical woman graduate, to our knowledge, has specialized in obstetrics and gynecology — a field in which there is a large public demand for women doctors. Probably the main reason for Harvard's women not entering this field has been the reluctance, so far, on the part of Harvard's surgical services to give internships and residencies to women. Some of the hallowed portal hinges are still in need of lubrication.
>
> A number of Harvard women have carried on with the Harvard tradition of teaching medicine, since over half of the female graduates have academic appointments in various medical schools, with a significant scattering of associate and assistant professors. . . .
>
> . . . Unlike other minority groups, women in medicine have made no demands, organized no protests or demonstrations . . . living up to the standards set up by males in a predominantly male profession. Perhaps they should make a little noise, voice some protests. . . .
>
> . . . Perhaps this anniversary could be used as a time for discussion of "how" to improve the situation for future women doctors during their medical school and working years.

Under the general heading, "Harvard Admissions and the Minority Group Student," an article by Alexandra Murray '71 appeared in the **July/August 1971** number of the *Alumni Bulletin,* "Women in Medicine":

> Women have much to give to medicine. Most of what they have to give is the same as what their male colleagues have to offer; hard work, intellectual discipline, technical skills, and compassionate concern for their patients. . . .
>
> . . . Women who make it to medical school admissions committees often face subtle, usually unconscious discrimination in the twilight zone of choosing among the "many qualified candidates." . . .
>
> . . . We are also urging a selective increase in women accepted by Harvard Medical School, and an associated increase in women accepted by the training programs of the Harvard teaching hospitals. We are encouraged to see that there will be 30 women in next year's first year class . . . We hope that our efforts will be even more productive next year.

Dr. Murray (now Dr. Harrison) elaborates on her views, four years later:

> I am impressed with the changes which have occurred in the past four years. There have been changes in increasing the availability of medicine as a career for women, as evidenced by larger numbers of women in medical school classes. There have been more general progressive changes in the role of women in contemporary society. Still, there are changes to be made.
>
> I see a need for more women physicians as supportive teachers and role models for women medical students and undergraduates. There is still a need for more equal opportunity in academic medicine and in medical subspecialties that traditionally have few women. The problems of increasing the number of women in high academic positions and in certain subspecialties is influenced not only by factors of prejudice but also by the fact that women physicians often take off time from their careers to raise families. Whether this "time off" constitutes actual part-time work or instead amounts to a temporarily smaller investment in professional ambition, the result is a compromise in professional input during a highly productive time in a medical career. This situation is not unique to medicine.
>
> Yet there is no reason why medicine could not lead the way toward establishing a pattern of greater flexibility in professional practice, one in which standards used to judge professional excellence incorporate humanitarian values. Certainly contemporary events have warned physicians to reexamine their professional lives. Perhaps this process of review will be initiated by women physicians.

In the **November/December 1972** *Alumni Bulletin,* an historic event for Harvard Medical School was announced:

> The first woman to be appointed to an associate deanship in the history of the Harvard Medical School is Mary C. Howell, M.D., Ph.D. Dr. Howell, 40, of Newtonville, Mass., was named associate dean for student affairs. . . .
>
> As associate dean, Dr. Howell will be involved in student career planning. She will work to strengthen the role of women in medical education, health maintenance, and the delivery of health care.

In April 1975, Dr. Howell resigned that post. Her reasons are apparent from a letter written to students she had worked with:

> The job of "woman administrator" would mean that a woman-identified woman would have some voice in the administrative policies of the school, especially with regards to matters concerning students. . . .
>
> . . . I have had little access or opportunity to affect policy — nor, indeed, even to attempt to convince the administration that issues of concern to women were valid and important. During a period of time when my opinions and advice have been widely sought at other schools, I have been almost invisible at Harvard. . . .
>
> . . . I can certainly tolerate the slowness of real change, but I do not see how real change will ever happen unless we have *access*.

In the column, "Reminiscences," in the **November/December 1972** issue of the HMAB, Dr. Leona Baumgartner told the story of why she went to Yale Medical School and not Harvard. She had wanted to work with Dr. Hans Zinsser and he had agreed that she would be acceptable as a Ph.D. candidate; her degree would come from Radcliffe rather than Harvard. Dr. Baumgartner expressed a desire to take gross pathology, at which Dr. Zinsser was forced to divulge what her fate would be:

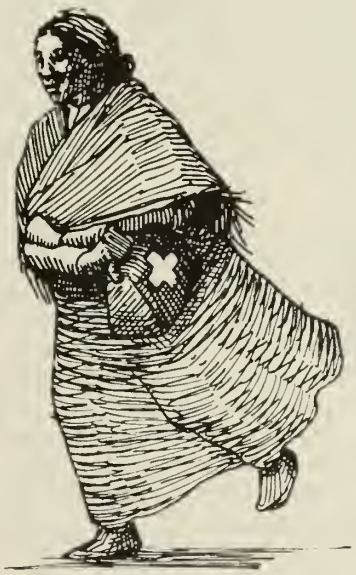
> In a most embarrassed manner, he explained.
>
> "You'll have to take human anatomy first," he said.
>
> "So what?" was my reaction.
>
> If Harvard thought I had to have it as a prerequisite, I was perfectly content to spend a year in the anatomy lab.
>
> Then came the blow. In an apologetic tone he announced, "We can issue you a cadaver." I took a few minutes for the meaning of those words to sink in. Because I was a woman, I would not be allowed to dissect in a laboratory at HMS, but if I paid my tuition, I could have the essential body to work on.
>
> But where? I had visions of sharing a room with my new companion and quickly gave that up. Rentals had seemed high to me already and what would the police or my landlady say? Sadly, I left Dr. Zinsser's office. He seemed sad, too, and again suggested I give up gross pathology.
>
> I decided to try Yale. . . .

Women and Success

by Mary Roth Walsh, Ph.D.

Women and Success: The Anatomy of Achievement. Ruth B. Kundsin, Sc.D., Ed., Morrow, New York, 1974. 256 pp. $7.95, paperback edition, $3.45.

In 1873, Harvard Medical School Professor Emeritus, Dr. Edward H. Clarke published a best selling book, *Sex and Education: A Fair Chance for the Girls*. The book quickly went through sixteen printings and its message — that women's reproductive capacity would be impaired by higher education — cast a shadow over schoolgirl dreams of that era. Years later, M. Carey Thomas, famous president of Bryn Mawr College, recalled the "gloomy spectre" of Clarke's book and its dire predictions for the educated woman: ". . . those grievous maladies which torture a woman's early existence, called leucorrhoea, amenorrhoea, dysmenorrhoea, chronic and acute ovaritis, prolapsus uteri, hysteria, neuralgia, and the like."



How ironic that a century after Dr. Clarke's book, another Harvard scientist, Dr. Ruth Kundsin, internationally known for her research on mycoplasmas and female reproductive failure, has published another book on women's chances for success. Unlike Dr. Clarke, who was openly hostile to feminine achievement in competitive medical circles, Dr. Kundsin has been an advocate for women and especially for women in the sciences.

Dr. Kundsin's editorial achievement, *Women and Success,* grew out of a 1972 conference of the New York Academy of Sciences on "Successful Women in the Sciences: An Analysis of Determinants." The volume comprises a section of autobiographical essays by twelve women in the sciences, nominated by peers in their fields; followed by the contributions of twenty-two writers in the social sciences on new research in women's psychology and the impact of familial, educational, economic and historical factors on their career opportunities. Three other successful women scientists and physicians acted as an advisory committee to Dr. Kundsin. Two of these, Iolanda E. Low '53 and Dr. Jane V. Anderson, are on the faculty of the Harvard Medical School; the third member, Dr. Mary G. Ampola is a Tufts Medical School professor. To date, more than 12,500 copies of the book have been sold, with the paperback version of the book now in its second printing. Enthusiastic book reviews have appeared in *Science*, *JAMA*, *The Sciences* and a number of women's studies journals.

How does *Women and Success* define the successful woman? Dr. Jo Ann Evans Gardner, a Ph.D. in chemistry, was thwarted in her effort to become a doctor by the five percent female admissions quota operating in most of the nation's medical schools in the 1950s. She defines success "in terms of whether or not people get to do what they perceive as their work. There are so many persons who are females who have not been able to do their work."

Two of the women who tell their life histories in *Women and Success* had careers in medicine. Dr. Gertrude Hunter, a pediatrician and currently Boston Regional Health Director for HEW, was able to overcome the double prejudice of race and sex in her career. Dr. Hunter's good fortune was to have crucial family support each time she encountered adversity in climbing the professional ladder. In high school, her faculty adviser tried to insist she enroll in the home economics curriculum with the argument: "What is a colored girl going to do with college?" Later, when Dr. Hunter entered Howard University Medical School, she once again had strong parental support. In addition, almost twenty-five percent of her classmates at Howard were also women and Dr. Hunter feels "pretty certain that the supportive milieu of Howard was instrumental in the eventual success of the females in my class." Later, when she married, she also chose a husband who "always expected people — and especially me — to perform at the very highest level of which they [were] capable."

Dr. Mary Calderone, the other female physician represented in the book's autobiographical section, had a quite different life history. Nonetheless, everyone in her family assumed she would go to medical school after Brearley School and Vassar College. She finally did this, too, in 1933, aided by a sizeable bequest to finance her education. As a divorced mother of two children, Calderone was far from the typical medical school student of that era.

We have come a long way since Dr. Clarke's impassioned plea against more educated women. As the fruits of the second feminist revolution of the twentieth century bring more women into medicine and other fields, books like *Women and Success* will inspire others who have professional aspirations, and edify those who would bar their way.

Mary Roth Walsh, Ph.D. is a postdoctoral fellow in the behavioral sciences at Radcliffe Institute/Harvard University. She is currently working on a project on the life histories of women physicians' career decisions.

Letters

To the Class of 1975:

I was very moved by your gift to me on the occasion of your graduation, and I appreciate the *Bulletin*'s help in thanking you properly. Certainly there could not have been a more appropriate book for me than Lewis Thomas's *Lives of a Cell*.

I am never quite emotionally prepared to see a class move on: as you know it's often hard to cope with the welter of feelings you experience at the beginning or the end — particularly the end — of anything. Nonetheless, I think you know that I wish you all well and appreciate more than I can say your thoughtfulness.

James J. Pates, Jr.
Director, Financial Aid

Nine to Pursue Psychiatry

A number of inquiries have come to me concerning a report by Toby Gerhart '75 which appeared in a recent issue of the *Alumni Bulletin*. He stated that only one member of his class was entering psychiatry.

The actual number who plan careers in psychiatry is nine. After talking with me, Dr. Gerhart realized that he made an inadvertent error, because he included only the choice of their first graduate year residency (formerly the internship). A few years ago, the American Board of Psychiatry and Neurology eliminated the requirement of an internship before entering a psychiatric residency. In 1976, the requirement for the internship will be reinstated. It must be in general internal medicine, general pediatrics, or general family medicine. Of the nine members of the class of '75 planning to enter psychiatric residencies, eight of them chose to take an internship first, and one entered directly into a psychiatric residency.

Although nine is a much lower number entering psychiatry from HMS than in the past, it is the highest number of any medical school in my national stratified sample of medical schools. Approximately half of the Harvard students who eventually plan careers in psychiatry held this choice firmly at matriculation. The other half who plan psychiatry by graduation, made this choice during Medical School. This has been true for each class during the past eighteen years.

The most interesting change in the career plans of Harvard students is the increasing number (forty per cent) who plan to practice primary care, not as general family practitioners, but as general internists or general pediatricians. Overall, ninety-seven per cent of the class plan to practice in groups, which is similar to that of graduates from other medical schools in my national sample.

Daniel H. Funkenstein, M.D.

New AOA Members

I am disappointed that you did not print the names of the twenty-seven members of the Class of 1975 elected to membership in Alpha Omega Alpha. The students with whom I came in contact at Harvard worked hard and it does not seem too much to devote perhaps two paragraphs of a sixty-one page issue to printing their names.

Grace J. Boxer, M.D.

Editor's note: These names were not printed because of past policy and the numerous other individual citations that were listed. Those members of the Class of 1975 elected to AOA are: Mary A. Badaracco, David Blumenthal, Nelson M. Braslow, Claire V. Broome, Robert H. Brown, Stephen B. Calderwood, Rosemary deL. Casey, Lionel M. Cobo, Arnold N. Cohen, Elisabeth J. Cohen, Elaine E. Farrell, James D. Iglehart, Julius A. Kaplan, Stephen P. Kelleher, Charles I. Krauthammer, Kathleen Kreiss, Paul W. Ladenson, Norman L. Letvin, Robert L. Nussbaum, Mark S. Pasternak, Morris M. Podolsky, Reed E. Pyeritz, Ellis L. Reinherz, John C. Russell, Mary E. M. Rybak, Robert C. Shamberger, and Gus J. Vlahakes.

Lost List

If any readers know the whereabouts of those listed below, please contact Alumni Records, Harvard Medical School, 25 Shattuck Street, Boston, Mass. 02115.

1908
Albert S. Tenney

1917
Hubert M. English

1924
Cornelius T. O'Connor

1927
Clyde S. Tarter

1931
Peter K. Knoefel

1933
Joseph M. Alper

1935
Herbert Parsons

1937
Col. John A. Booth

1938
James E. Davidson

1944
Blair Van H. Thatcher

1945
Earl G. Broderick
Walter Eberline

1949
Alan W. Petit

1951
Bernard M. Tully

1952
William S. Branaman, Jr.
James T. Dowling
David P. Michener

1953
Jason L. Starr

1956
Wayne P. Cochrell
Donald F. Muhick

1957
Adolph Stern

1958
G. Hubbard Randall

1959
Hall Downes

1960
James A. Powers
Raphael F. Smith

1962
Eugene Dicero
William C. Donahue
Michael E. Pollatsek

1963
Joseph T. Okimoto

1965
Charles D. Kenyon

1966
Gerald B. Colman
Mahlon R. DeLong
Richard H. Kaldor
Michael L. Kern
Phillip H. Taylor
David H. Wegman

1967
Charles M. Bagley
Kenneth M. Berc
William E. Bucknall
Stanton P. Goldstein
C. Robert Hayes
Alexander B. Latty
Michael J. Lisanti
Daniel P. O'Neill
Antony Weikel

1968
David T. Harris
Stephen H. Hochschuler

1970
David A. Boetcher
William A. Bours IV
Peter R. Camfield
Robert T. Fritz
Ronald F. Goldberg
Edward E. Gustavson
William M. Keane
Jeffrey L. Rogers
Phillip H. Wade
Edward I. Walkley II

1971
David M. Bear
David R. Brown
Robert S. Fishman
Janet G. Hickman
Raymond Kempf
Cornelius A. Kolff
Larry Martel
James T. Orme
Jeffrey A. Partnow
Frank J. Voralik

1972
William W. Chin
William J. Koopman III
Andrew B. Larkin
Sara G. Rosenthal
Frank L. Smith
John W. Sparks

1973
Wallace A. Arneson, Jr.
Charles Davis Belcher, III
John J. Coleman III
Michael S. Greenfield
Robert Duke Lonian
Patricia Hughes Moore
William Tobey Wickner

1974
Steven B. Abramson
Seth P. Finkelstein
Hasan Garan
Peter N. Gorlin
Francis N. Griffin
Robert E. Hall
Albert J. Hudspeth
Dennis M. Hull
Joseph A. Kane
Mitchell B. Max
Willie R. McDaniel
Palmer H. Moore
Harry E. Morgan
Catherine M. Nelson
Velvie S. Pogue
Richard Rivera
Eddie Skipper
John R. Stanley
David N. Taylor
Robert E. Vanderlinde